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HEALTH CARE REFORM

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Health Care Reform, Serial No. 103-...

RINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

VOLUME VII

President's Health Care Reform Proposals:

Impact on Labor

OCTOBER 28, 1993

Issues Relating to Long-Term Care

NOVEMBER 2, 1993

Impact on the Economy and Jobs

NOVEMBER 4, 1993

Serial 103-76

Printed for the use of the Committee on Ways and Means



Committee on Ways and Means
Neurology

SEP 21 1993

STANDARD & POOR'S
COMMITTEE ON WAYS AND MEANS

HEALTH CARE REFORM

HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
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PRESIDENT'S HEALTH CARE REFORM PROPOSALS: IMPACT ON LABOR

THURSDAY, OCTOBER 28, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:07 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearings follow:]

FOR IMMEDIATE RELEASE
THURSDAY, SEPTEMBER 30, 1993

PRESS RELEASE #18
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a series of hearings on issues relating to the President's health care reform proposals.

The hearings will begin on Thursday, October 7, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building. They will continue on Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. Subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President's health care reform plan presents a comprehensive response to the nation's most pressing problem. The plan would commit the nation to universal health coverage and to cost containment -- goals we have been seeking for many years. The President's proposals are complex, and we want to explore this plan and the alternatives to it, thoroughly, before proceeding to mark up a bill. We, therefore, expect to hold hearings to examine various aspects of the proposals throughout the fall of 1993."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals.

BACKGROUND:

The first hearing, scheduled for October 7, will include testimony from representatives of affected groups, including labor unions, health care providers, and health insurers.

Testimony from Administration experts on various aspects of the President's proposals, including benefits, coverage, low-income subsidies, cost containment, governance, and Medicare proposals, will be heard by the Subcommittee at the next two hearings. The first day of Administration witnesses will be held on October 12, and the second day will be announced in a later press release.

At subsequent hearings the Subcommittee will receive testimony from Members of Congress and from representatives of other affected groups, including consumer and employer groups.

Testimony will be heard at additional hearings to focus on a series of priority health reform issues, including:

- (1) Role of State governments and the Federal Government, including the role and functions of the proposed National Health Board, the Department of Health and Human Services, and other Federal agencies;
- (2) Role and functions of the proposed health alliances;
- (3) Health cost containment, including premium caps and alternative mechanisms;
- (4) Proposed insurance reforms and their impact, risk selection, and risk adjustment;

- (5) Impact of the plan on underserved inner-city and rural areas;
- (6) Impact of the plan on low-income populations generally;
- (7) Medicare savings proposals;
- (8) Impact of the plan on the structure and future of the Medicare program, including the proposed Medicare drug benefit;
- (9) Alternatives to the plan, including single-payer options, and other managed-competition options;
- (10) Administrative simplification under the plan;
- (11) Quality assurance;
- (12) Fraud and abuse measures;
- (13) Retiree health benefits;
- (14) Long-term care benefit;
- (15) Proposed standard health benefit package;
- (16) Graduate medical education and academic medical centers;
- (17) Impact of the plan on other affected groups and individuals.

Hearings also will be scheduled by the full Committee on Ways and Means to consider financing issues (other than Medicare savings proposals) and other tax-related matters.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Members of Congress, individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland or Karen Ponzurick [(202) 225-1721] no later than the close of business on Friday, October 15, 1993, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline and after additional hearings have been scheduled.

Individuals and organizations must specify in their requests to testify on which topic they would like to be heard. Given the limited time for the Subcommittee to hear from public witnesses, it is likely that witnesses will be restricted to one scheduled appearance before the Subcommittee. Additional comments on other aspects of the President's proposals may be submitted for the printed record of the appropriate hearing.

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Witnesses are reminded that the Subcommittee has held extensive hearings on various health reform issues earlier this year. To the extent possible, witnesses need not restate previous testimony heard by the Subcommittee.

Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittee are requested to submit 300 copies of their prepared statements to the Subcommittee office, room 1114 Longworth House Office Building, at least 24 hours in advance of the scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will ~~not~~ be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

FOR IMMEDIATE RELEASE
WEDNESDAY, OCTOBER 6, 1993

PRESS RELEASE #19
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will continue its series of hearings on issues relating to the President's health care reform proposals with two hearings focusing on testimony from Administration witnesses.

The hearing previously announced for Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m., will begin at 10:30 a.m. All other details for this hearing remain the same. (See Subcommittee press release #18, dated September 30, 1993.)

The Subcommittee will continue its hearings on Friday, October 15, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The dates, times, and rooms for subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President has put forward a comprehensive and complex plan to address the critical goals of universal coverage and cost containment. As a follow-up to full Committee hearings with the First Lady and Secretary Shalala, the Subcommittee will hold two hearings with additional Administration officials to explore the proposed health plan in detail."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

BACKGROUND:

On October 12, the Subcommittee will receive testimony from the Administrator of the Health Care Financing Administration, the Honorable Bruce C. Vladeck. Mr. Vladeck's testimony will focus on various aspects of the President's proposal, including the methodology for controlling the rate of growth in public and private health care spending, the employer and individual mandates, subsidies for firms with fewer than 50 employees, subsidies for low-income individuals, retiree health benefits, the Medicare prescription drug benefit, and more generally, the future of the Medicare program.

Judy Feder, Ph.D, Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, will appear before the Subcommittee on Friday, October 15th. Dr. Feder's testimony will cover issues of governance under the Administration's health care reform plan, including the role of the States, various Federal agencies, the National Health Board and the alliances. She will also focus on essential providers, insurance reforms and long-term care.

* * * CHANGE IN SCHEDULE * * *

FOR IMMEDIATE RELEASE
FRIDAY, OCTOBER 8, 1993

PRESS RELEASE #19-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES SCHEDULING CHANGES FOR HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today scheduling changes for the hearings on issues relating to the President's health care reform proposals with testimony from Administration witnesses. (See Subcommittee press release #19, dated October 6, 1993.)

The hearing previously announced for Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m., will be held on Thursday, October 14, beginning at 10:00 a.m.

On Thursday, October 14, Judy Feder, Ph.D., Principal Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, will appear before the Subcommittee. Dr. Feder's testimony will cover issues of governance under the Administration's health care reform plan, including the role of the States, various Federal agencies, the National Health Board and the alliances. She will also focus on essential providers, insurance reforms and long-term care.

The Administrator of the Health Care Financing Administration, the Honorable Bruce C. Vladeck, originally scheduled to appear on Tuesday, October 12, 1993, instead will appear before the Subcommittee on Friday, October 15, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Mr. Vladeck's testimony will focus on various aspects of the President's proposal, including the methodology for controlling the rate of growth in public and private health care spending, the employer and individual mandates, subsidies for firms with fewer than 50 employees, subsidies for low-income individuals, retiree health benefits, the Medicare prescription drug benefit, and more generally, the future of the Medicare program.

For additional information about these hearings and other Subcommittee hearings, see Subcommittee press releases #18, dated September 30, 1993, and #19, dated October 6, 1993.

* * * * *

FOR IMMEDIATE RELEASE
FRIDAY, OCTOBER 15, 1993

PRESS RELEASE #20
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled two additional hearings as part of its series of hearings on issues relating to the President's health care reform proposals.

The Subcommittee will hold a hearing on Thursday, October 21, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m., with testimony from representatives of consumer groups.

On Friday, October 22, 1993, the Subcommittee will hear testimony from provider groups beginning at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings, however, will be notified in advance by the staff.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about the hearings, see Subcommittee press release #18, dated September 30, 1993.

* * * * *

FOR IMMEDIATE RELEASE
WEDNESDAY, OCTOBER 20, 1993

PRESS RELEASE #21
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled additional hearings as part of its series of hearings on issues relating to the President's health care reform proposals.

The dates, times, rooms, and topics for the additional hearings are as follows:

Tuesday, October 26	9:00 a.m.	1100 Longworth	Provider groups
Thursday, October 28	10:00 a.m.	1100 Longworth	Labor representatives
Tuesday, November 2	10:00 a.m.	1100 Longworth	Long-term care issues
Thursday, November 4	11:00 a.m.	1100 Longworth	Impact on the economy and jobs
Friday, November 5	10:00 a.m.	1100 Longworth	Role of State governments and health alliances
Tuesday, November 9	10:00 a.m.	1310A Longworth	Issues relating to risk selection and adjustment by health plans
Monday, November 15	10:00 a.m.	1310A Longworth	Health care cost containment

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings, however, will be notified in advance by the staff.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

* * * * *

* * * CHANGE IN ROOM AND TOPIC * * *

FOR IMMEDIATE RELEASE
MONDAY, NOVEMBER 8, 1993

PRESS RELEASE #21-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A CHANGE IN ROOM AND TOPIC FOR THE HEARING ON
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the President's health care reform proposals scheduled for Monday, November 15, 1993, at 10:00 a.m. in room 1310A Longworth House Office Building, will be held instead in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. (See press release #21, dated Wednesday, October 20, 1993.)

The topic of this hearing will not be health care cost containment. Testimony will be heard instead from public witnesses on issues relating to benefits under the President's health care reform proposals.

The Subcommittee hearing on health care cost containment will be rescheduled at a later date.

* * * * *

FOR IMMEDIATE RELEASE
FRIDAY, JANUARY 14, 1994

PRESS RELEASE #23
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES ADDITIONAL HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee has scheduled two additional days of hearings to receive testimony from the public, as part of its series of hearings on issues relating to the President's health care reform proposals.

The first hearing will be held on February 1, 1994, in room 1310A Longworth House Office Building. This hearing will begin at 2:30 p.m. or, if necessary, upon completion of the earlier full Committee hearing.

The second hearing will be held on Friday, February 4, 1994, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will be individuals and organizations who have previously requested an opportunity to testify before the Subcommittee, in accordance with Subcommittee press release #18. All witnesses who will appear at these hearings will be notified in advance by the staff.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearings should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

* * * * *

* * * NOTICE -- CHANGE IN TIME * * *

FOR IMMEDIATE RELEASE
MONDAY, JANUARY 24, 1994

PRESS RELEASE #23-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A TIME CHANGE FOR HEARING
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee hearing on the President's health care reform proposals previously scheduled for Tuesday, February 1, 1994, at 2:30 p.m. in room 1310A Longworth House Office Building, will begin instead at 10:00 a.m.

All other details for the hearing remain the same. (See Subcommittee press release #23, dated January 14, 1994.)

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Chairman STARK. Good morning. The Subcommittee on Health will continue with its hearings on health care reform, with testimony from groups representing organized labor in the United States.

Yesterday, the President transmitted his health care reform legislation, the Health Security Act of 1993. At the request of the President and because I strongly support the goals to which the President has committed himself, universal health coverage and cost containment, I have cosponsored the bill.

Our witnesses today have a longstanding commitment to universal health coverage, cost containment, and quality care. This hearing should provide an opportunity for them to comment on various aspects of the plan, and we would encourage comments on various alternatives to sections of the President's plan.

Before proceeding, I want to recognize the ranking member, Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

At long last, we have the bill before us, blank pages and all, and also on CD-ROM so we can do word searches and that sort of thing, which I think is a new and novel approach.

I look forward to the testimony of those individuals who, given the area that we are dealing with, have a vital concern in, first of all, health care itself, and second, any fundamental changes that may be brought about by the government.

We look forward to the testimony of the labor representatives, because they have had over the last two decades, as a major component of their negotiations with employers, the question of health benefits being the central focal point. The Clinton plan contemplates changes in that area.

Mr. Chairman, I look forward to the testimony. By the way, I have not cosponsored the President's plan.

Chairman STARK. There is still time.

Mr. THOMAS. I understand there is still time to make fundamental changes so that I can cosponsor it, Mr. Chairman.

Chairman STARK. Would other members have any comment?

Mr. McDERMOTT. Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Mr. Chairman, last Thursday, an inaccurate, and in my judgment, an inappropriate remark was made here. It requires a response and it should not be allowed to pass without comment.

In testimony before the subcommittee, the group Consumers Union stated its support for the single-payer plan. As a coauthor of the bill H.R. 1200, I am proud to have their support. What does not make me very proud is the response they received from one member of the subcommittee. They were told, and by no less than the ranking member of the subcommittee, that if the Consumers Union continued to support single-payer legislation, they simply wouldn't "be a player" in the coming debate and deliberations on health care reform. That requires a response, Mr. Chairman.

Apparently, the ranking member lacks a few basic facts. Since, as he knows, I always try to be helpful, I would like to provide a few facts. There is a somewhat broader question involved here, and I would like to address that as well.

First, let me take the accuracy question. As I said, Mr. Chairman, I am the coauthor of H.R. 1200. We have 89 cosponsors in the House. We count among that number more than one-third of the House Democratic Caucus, 82 percent of the Congressional Black Caucus, 50 percent of the Congressional Hispanic Caucus, and more than one-third of first-term House Democrats. Now surely the ranking member doesn't mean to suggest that they are all irrelevant in the coming debate because they support single-payer.

As you know, Chairman Stark, we are also proud to count you among the cosponsors of H.R. 1200. We appreciate the leadership you are providing in this historic effort to reform the nation's health care system, and we are delighted to have you with us as a cosponsor on the single-payer plan. I am quite certain that the ranking member did not mean to suggest that the chairman of this subcommittee will be irrelevant because he, too, supports a single-payer plan.

Surely it doesn't mean to suggest that Mr. Lewis of Georgia, our colleague on the subcommittee and a Deputy Majority Whip of the U.S. House of Representatives, is also irrelevant in the process because he cosponsored H.R. 1200.

We are also proud to count the ranking Democrat on the Ways and Means Committee, Mr. Gibbons, the third-ranking Democrat, Mr. Rangel, and four of the six Ways and Means Subcommittee chairmen as our cosponsors. Surely the ranking member does not mean to suggest they are all irrelevant because they support the single-payer plan.

Now among the cosponsors of H.R. 1200, you will find the Chairs of the following full committees: Rules, Post Office and Civil Service, Armed Services, Budget, Small Business, and the ranking member on the Veterans Affairs Committee. No, the ranking member couldn't possibly seriously suggest that they are all irrelevant to the process because they support the single-payer system.

But the broader issue, Mr. Chairman, is about our proper role here. I don't believe it is the role of any member of this subcommittee, the Ways and Means Committee, or the Congress to tell anyone, colleague or citizen, that their views do not count. The American people will decide who is a player and who is not a player in this debate. The purpose of these hearings is to listen to the American people.

The notion is, frankly, absurd that Members of Congress can declare irrelevant the organization the American people look to for advice on everything from purchase of radios to automobiles, simply because it objectively concludes that the single-payer is the best for the American consumer. One can only wonder whom would make such a statement would think would be left at the table when the Consumers Union is gone.

What the Consumers Union said last Thursday was appropriate. It was to this member, and at least 88 other members, quite welcome. It is not appropriate for any Member of Congress to try to read them or anyone else out of the process because of the view they bring to the table.

Thank you, Mr. Chairman.

Chairman STARK. In an effort to head off what could be a rather lengthy debate, I could shorten it a lot by stipulating that the

Chair has been called a lot worse things than irrelevant in his career and that doesn't trouble me at all. [Laughter.]

I would further like to, before I recognize the ranking member to respond, suggest that I have myself indicated to some groups that they could be, and I tried not to use the word irrelevant, but they would lose their ability to participate in the debate if they dug in their heels and said they would not debate. We have had groups that have just said no, and it is very difficult to negotiate with the position of no. As people harden their position to that limited alternative, they do, in a sense, become irrelevant to the debate.

I don't interject that into my distinguished colleague from Washington's comments. I just want to say that the Chair has, from time to time, suggested on those grounds that people could lose their importance in the debate.

With that brief cooling-off period, I recognize my distinguished colleague from California, Mr. Thomas.

Mr. THOMAS. I thank the chairman.

No cooling-off period is needed, because the gentleman from Washington wasn't here, didn't understand the context in which the comment was made, did not ask me what I meant in the context of what was said, but apparently took other people's comments.

I resent the fact that he didn't talk to me beforehand. If he would like to look at the notes from the conversation or the testimony from the Consumers Union or read the responses from Gail Shearer, who represented the Consumers Union, he would understand that his interchanging of the words "irrelevant" and "not a player" is a fundamental mistake.

I did not say they were irrelevant. I have never told anyone they are irrelevant. But when I asked a question, based upon their testimony, have you costed out your suggested changes or requirements? The response was basically: I don't care what they cost. I said, you can't do everything you have outlined. What should be done? Can we talk about capping deductions? We went through a series of alternatives.

When the representative from the Consumers Union basically said, it is our way or no way, this is what should be done, I said, if you maintain that position, you are not going to be a player in this. You have to be flexible. You have to look at alternatives. I did not say at any time that they were irrelevant.

Your rushing to the microphone to espouse a position that I did not advocate, and your unwillingness to consult with me as to what I advocated is, in fact, uncharacteristic of the gentleman from Washington and clearly indicates the pressure he is operating under. Frankly, anybody who does not now look at reasonable alternatives is not going to be a player.

The chairman opened up this hearing by saying that although he is an advocate of single-player, he has cosponsored the President's plan. That, by definition, makes him a player. Anyone who sits on the sidelines now and says, this is the way it has got to be, I don't accept any changes, and if you don't buy my argument then there is something wrong with you is, and I will repeat it, not going to be a player in this process.

That was the context in which it was delivered. That was the way in which it was meant. If somebody is going to be inflexible and demand their position, they are not and they will not be a player.

Chairman STARK. I thank the gentleman for his comments.

Are there other opening comments?

[No response.]

Chairman STARK. If there are none, the Chair is pleased to recognize John J. Sweeney, who chairs the AFL-CIO Health Care Committee. In his spare time, he is the international president of the Service Employees International Union of the AFL-CIO.

I would like to welcome you, Mr. Sweeney, to the subcommittee. As with all of the witnesses today, your full written statements will be a part of the record of this hearing. In addition, I would like to ask all witnesses to limit their oral statements to approximately 5 minutes to allow adequate time for members to explore particular issues of interest, thereby making you very relevant to this conversation and to this process.

If you would like to expand on your written testimony or summarize it in any way you are comfortable, please proceed.

STATEMENT OF JOHN J. SWEENEY, CHAIR, AFL-CIO HEALTH CARE COMMITTEE, AND INTERNATIONAL PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS; ACCOMPANIED BY CALVIN JOHNSON, LEGISLATIVE DEPARTMENT, AND JERRY SHEA, DIRECTOR OF EMPLOYEE BENEFITS, AFL-CIO

Mr. SWEENEY. Thank you very much, Mr. Chairman and members of the committee. Thanks for the opportunity to testify on one of the most critical issues facing our nation today.

With me is Calvin Johnson, a representative of the Legislative Department of the AFL-CIO, and Jerry Shea, the director of Employee Benefits for the AFL-CIO.

After almost 50 years of struggle, we are on the verge of bringing much needed reform to our nation's health care system. The delivery of the reform legislation to the Congress yesterday by the President and First Lady was an historic step forward for the working men and women of this nation. We agree wholeheartedly with President Clinton that in changing times, health security is a critical component of economic security.

Let me also take this opportunity to applaud the Chair of this committee for your outstanding leadership in this area over the years.

I am here on behalf of the affiliated unions of the AFL-CIO, which represent over 16 million working men and women across the United States.

Our members don't need charts and graphs or expert pronouncements to understand that there is a crisis in our health care system. Over the last decade, health care has been the number one issue at the bargaining table and the number one cause of strikes. Our members have fought hard to hold onto their health insurance, often foregoing wage increases and benefit improvements to maintain coverage for themselves and their families.

We support the President's plan because it meets all of the AFL-CIO principles for reforming the current system. Delegates at our recent convention adopted a resolution endorsing the President's principles and committing the AFL-CIO to a strong effort to secure comprehensive health care reform.

My written statement presents our views on the major elements of the President's plan for the record. What I want to do this morning is highlight some key issues that critics of the plan have seized on and explain why the AFL-CIO believes that President Clinton has taken the proper course.

The first and most important issue that I want to discuss is the question of universal health insurance coverage. It should be a source of shame to us that in the richest nation on earth, there are 37 million people without any form of health insurance whatsoever.

President Clinton's plan would guarantee every American access to a comprehensive range of health care benefits. The President has said that universal coverage is not negotiable, and the men and women of the trade union movement are in complete agreement with him. Making health insurance more affordable through voluntary health alliances and tax vouchers will not reach many of the uninsured.

This leads me to my second issue, the employer mandate. Many employers and employer organizations are opposed to a mandate and wish to continue the current system of voluntary coverage. The strength of the employer mandate approach is that it builds on the present system. The majority of employers and even the majority of small employers already provide health insurance for their workers. It is also attractive because 85 percent of the uninsured are workers and their dependents.

The employers who are currently providing health insurance are doing so even though they pay more than their fair share. They pay more to ensure their employees' working dependents whose employers do not provide insurance. They also have to pay more so that doctors and hospitals continue to provide care to the uninsured.

Opponents of the President's plan have predicted that the employer mandate will lead to huge job losses. These are the same arguments that are often used against the minimum wage, despite the fact that real world evidence does not support those arguments.

The next issue that I want to address is the question of who benefits from reform. It has been suggested by some opponents of the President's plan that it benefits large unionized manufacturing industries at the expense of small businesses in the service sector.

The truth is that the Clinton plan, by getting health care costs under control, will benefit all businesses. Small businesses are actually among the biggest winners under the President's reform plan. The majority of small businesses already provide health insurance to their workers and will benefit from large group purchasing, from the elimination of cost shifting, and from generous premium discounts. Of the \$110 billion that the plan budgets for business subsidies, the vast majority will go to small business.

The third issue I want to raise is the President's proposal to lift the heavy burden on businesses competing in the global marketplace by subsidizing the crippling costs of early retiree health in-

urance. This is sound health policy. It is also intelligent economic policy.

All of the United States international competitors spread the cost of retiree coverage across their population. If the U.S. wants to retain core industries in the global market, we will need to do the same in order to keep prices competitive and free up funds for productivity-enhancing investments.

The final issue I want to address is President Clinton's cost containment strategy, which uses a blend of regulation and market pressures to bring costs under control. The Clinton plan envisions consumer control, regional health alliances aggressively negotiating with plans under the discipline of an overall budget.

In California, there is a working model of this strategy. I am referring to the California Public Employees Retirement System, known as CalPERS, which administers a health benefits plan for 900,000 State and local government workers and their families. This past year, CalPERS held premium increases for its plan to an average of 1.5 percent, compared 10 to 12 percent nationally.

CalPERS achieved this remarkable level of cost containment by behaving exactly like health alliances are meant to behave under the Clinton plan. In response to California's fiscal crisis, the State government effectively imposed a budget on CalPERS by freezing contributions to it. CalPERS used its clout as a multiemployer purchasing cooperative, a giant consumer, to aggressively negotiate limits on premium increase charged by CalPERS.

I think that there are at least three lessons that can be drawn from the CalPERS experience that would argue in favor of President Clinton's approach. The first is that the discipline of an overall budget is critical to keeping costs under control. Before the imposition of a budget, premium rates in the CalPERS system were increasing faster than the national average. No other nation relies solely on the market to control health care costs, and we should not be expected to, either.

The second lesson is that consumers must be able to control the health alliance. The CalPERS board represents public sector workers and employers, not providers or insurers. Their presence ensures that CalPERS negotiators are willing to aggressively negotiate with plans to keep costs under control.

The third lesson is that while CalPERS may have saved money for its employers, insurers and employers may have simply shifted their costs to other California employers. If the employee ceiling on a health alliance is lowered or if they are made voluntary, it will be much easier for health plans to continue to play the cost shifting game. Health plans will continue to segment the market, offering discount rates to large employer groups and passing on the costs to smaller groups with less market power. It should be noted that the rate of growth in the health care costs for the State of California as a whole has also been unaffected by CalPERS.

Mr. Chairman, I want to compliment you for having scheduled this hearing for the morning after the release of the President's legislation. I will not claim to have digested the 1,300 pages in the 24 hours since its release, but over the next few days, we will be examining the bill, especially the changes that have been made,

and we look forward to discussing the details with yourself and the rest of the committee in greater depth over the next several weeks.

By way of conclusion, let me say President Clinton's initiative and his political commitment to health care reform offers the best hope for achieving our long-sought goal of universal health coverage. The men and women of the labor movement intend to defend President Clinton's proposal against those who will advocate that we move slowly, that we make incremental changes, or simply endure our current situation.

We are committed to spearheading a coalition of consumers, senior citizens, businesses large and small, community groups, and progressive providers to fight against those special interest groups defending their financial stake in the status quo.

I want to thank the chairman and the members of the Committee for the opportunity of testifying. We look forward to working with you to make President Clinton's vision of health care that's always there a reality for America's working families.

[The prepared statement follows:]

TESTIMONY OF JOHN J. SWEENEY
CHAIR OF THE AFL-CIO HEALTH CARE COMMITTEE
INTERNATIONAL PRESIDENT
SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

October 28, 1993

Mr. Chairman, members of the committee, thank you for this opportunity to testify on one of the most critical issues facing our nation today. After 50 years of struggle, we are on the verge of bringing much needed reform to our nation's health care system. We applaud the President and Mrs. Clinton for tackling this issue, and I am pleased to be invited to testify before this subcommittee on our views on the President's proposal. Let me also take this opportunity to applaud the chair of this subcommittee for your outstanding leadership in this area over the years.

Affiliated unions of the AFL-CIO represent over 16 million working men and women across the United States. They work in thousands of different jobs in dozens of industries. They build our homes, make our cars, bake our bread, tend our sick, and deliver our public services.

Our members don't need charts and graphs or expert pronouncements to understand that there is a crisis in our health care system. Over the last decade, health care has been the number one issue at the bargaining table. Our members have fought hard to hold on to their health insurance, often foregoing wage increases and benefit improvements to maintain coverage for themselves and their families. They have faced greater out-of-pocket costs and declining choices, as employers have tried to restrict where and when they can see their family doctors. While disagreements over health care issues have made collective bargaining more contentious than it otherwise would have been, labor and management have also worked together to pioneer new cost containment strategies such as utilization review and managed care. While these measures showed some short-term success, they were unable to blunt the long-term rise in costs. Only system-wide reform can provide the relief that workers and their employers need.

We support the President's comprehensive plan because it meets all of the AFL-CIO principles for reforming the current system. The plan calls for universal access to care for all Americans, regardless of health or employment status, real cost control, quality improvement, and fair and equitable financing. A resolution endorsing the President's proposal and committing the Federation to a strong effort to secure comprehensive health care reform was unanimously adopted by the delegates to our recent biennial convention.

President Clinton's reform proposal would dramatically improve the economic situation of workers, their families and the businesses for whom they work. The proposal would also alleviate pressure on state and federal government budgets which are being severely strained by the rapidly rising cost of public health care programs.

Controlling Costs

A recent study by the Service Employees International Union (SEIU) and Lewin-VHI examined the effects of health care cost inflation since 1980 on workers, business, and government. The study compared their actual experience with what they would have experienced if health care inflation had grown only at the rate of overall growth in the economy (an average of 8.3 percent per year over 12 years). The study concluded that if health care

inflation had been held to 8.3 percent per year:

- Real wages would not have declined.
- Employers would be paying an average \$1,015 less per employee per year--a savings of one-third of the cost of health insurance coverage.
- The smallest businesses would be helped even more and would be paying an average of \$1,283 less per employee per year.
- U.S. companies would be more competitive, with health care in the U.S. consuming roughly the same proportion of GNP as it does with our major trading partners (instead of 1.5 to two times as much).
- Our states would have had an extra \$34.9 billion available in 1992.
- The federal government would have saved \$79 billion in 1992 alone.

In addition to the working men and women of this country suffering real wage cuts over the last 12 years due to rampant health care inflation, their budgets have also been strained as employers have instituted cost-sharing programs in an effort to cope with soaring costs.

A 1991 study by Families USA found that the share of health insurance premiums paid by workers increased markedly between 1980 and 1991. In 1980, employees paid 18 percent of the cost of employer-sponsored health insurance. By 1991, that percentage had increased to 23 percent. If this trend continues, the average worker soon will be contributing 26 percent of the cost of their health insurance. It is important to bear in mind that this is an average, and that millions of workers will be paying much more.

These figures illustrate the profound need for health care reform, and what we stand to gain from it. If present trends are not reversed, health care will consume one-fifth of our national income by the year 2000, diverting society's scarce resources from pressing investments and social needs.

For these reasons, the AFL-CIO strongly supports President Clinton's cost control strategy, which uses a blend of regulation and market pressures to bring costs under control. Opponents of the President's plan have argued that with a little tinkering here and there, market forces alone would be sufficient to accomplish this task. This flies in the face of our experience over the last decade with deregulation in the health care industry. Reagan-era reliance on market forces brought us the highest rates of medical price inflation ever. Furthermore, no other nation in the world relies solely on the market to control health care costs. While the specific regulatory tools vary from country to country, all nations with national health care systems have imposed some kind of limit on the amount they spend on health care.

Those who oppose the implementation of a system-wide budget through caps on private insurance premium cost increases argue that it will lead to rationing of health care. The truth is that health care is already being rationed under the current system. Some of the highest quality health care services in the world are available in this country, for those who can afford it. The fact that such services exist, however, is little solace to the tens of millions of our citizens who are uninsured or underinsured.

It is also ironic that the so-called health care reform bills that are competing with the President's proposal would significantly weaken the role of Health Alliances, whose purpose is to *increase* the amount of competition between health plans. Under the President's plan, all businesses with fewer than 5,000 workers would be required to join the regional Alliance.

In California, there is a working model of what a well-operating health alliance can accomplish. The California Public Employees Retirement System (known as CalPERS), administers a health benefits plan for 887,000 state and local government workers, family

members and retirees, many of whom are members of the Service Employees International Union. This past year, CalPERS held premium increases for its plans to an average of 1.5 percent, compared to 10 to 12 percent nationally.

CalPERS achieved this remarkable level of cost containment by behaving exactly as health alliances are intended to operate under the Clinton plan. In response to California's fiscal crisis, the state government effectively imposed a budget on CalPERS by freezing contributions to it. CalPERS used its clout as a multi-employer purchasing cooperative—a giant consumer—to aggressively negotiate limits on premium increases.

Critics of the President's proposal on Health Alliances have suggested reducing the 5,000 employee threshold significantly or making membership in Alliances completely voluntary. Either course would be a significant mistake. If the employee ceiling on Health Alliances is lowered, or if they are made voluntary, it will be much easier for health plans to continue to play the cost shifting game. Health plans will continue to segment the market, offering discount rates to large employer groups and passing on the costs to smaller groups with less market power.

There is evidence that the unintended consequence of CalPERS remarkable success has been higher rates for many smaller employers who are not part of the CalPERS system. The rate of growth in health care costs for the state as a whole has also been unaffected by CalPERS, suggesting that even large purchasing cooperatives cannot effectively control costs unless virtually all employers are members of the same pool.

One cost-control strategy that we emphatically do not endorse is subjecting workers to increased levels of cost-sharing. We do not believe that consumers are to blame for over-utilization. People seek care when they are sick and rely on doctors and other health professionals to guide their treatment and to make decisions regarding their care. Blaming a patient for the high cost of a hospital visit is like blaming a robbery victim for the high cost of a crime. Most working Americans, including most union members, have watched their out-of-pocket costs for health care skyrocket over the last decade. They do not need to hear from academics and economists about the need for consumers to be more conscious of the cost of the health care they purchase.

Expanding Access

It should be a source of shame to us that in the richest nation on earth there are 37 million people without any form of health insurance whatsoever. As many as 50 million more are underinsured and often do not discover the crucial gaps in their health insurance until it is too late. In addition to the high cost of health insurance, many individuals and families are denied coverage because their employer does not provide it or because of pre-existing conditions that the insurance company refuses to cover.

The members of the AFL-CIO have long supported a universal right of access to health care. President Clinton's plan would eliminate existing barriers to coverage and guarantee every American access to a comprehensive range of health care benefits. No one would be denied coverage because of their income, health or employment status.

Universal coverage has become the key dividing line between the President and his conservative opponents. The Cooper bill, for example, does not provide for health care for every American. Making health insurance more affordable through voluntary health alliances and tax vouchers simply will not reach many of the uninsured.

There are also some opponents of the President's plan who argue that the benefit package is too generous and that we must limit the range of benefits available. The AFL-CIO would strongly oppose any move in this direction. While comprehensive, the administration's proposed benefit package is not "gold plated" health care and represents the *minimum* that all Americans should be entitled to.

Universal coverage is also an important element in cost containment. Uninsured persons still seek care, often through very costly and inefficient mechanisms. These costs are passed on by providers to their paying customers, the insured population. Under the President's plan, the financing burden of covering the uninsured will be distributed more equitably.

President Clinton's proposal will also give the majority of insured Americans a far greater range of provider and plan choices than they have now. Under the current system, employers choose what plans are available to their workers. As costs have risen, employers have sought to restrict choice as a way of containing costs. Under the Clinton plan, workers will be able to choose from any health care plan in their region.

Fair Financing

The AFL-CIO is also supportive of the way in which the President and his team of advisors resolved some of the issues related to the financing of the health care reform effort. We have supported progressive financing that distributes the costs of health care reform as broadly and equitably as possible.

The Clinton Plan requires all employers to contribute *at least* 80 percent of the cost of the average premium in their region. But many employers, especially those who pay poverty level wages and provide no health benefits, are resisting and want more of the burden shifted to workers and their families.

This would be exactly the wrong direction for the Congress to move in. It would encourage employers to seek the "low wage path" to competitiveness. The Clinton Plan, by requiring that all employers contribute, begins the process of taking benefits "out of competition" and denies unscrupulous employers the ability to gain a competitive advantage by denying needed benefits to their workers.

The AFL-CIO is also strongly opposed to "individual mandates," which would shift the responsibility for providing health coverage from employers to families. Many employers would end up dropping their health plans, forcing middle class workers to foot the bill.

Some employer associations have complained bitterly about the cost of an employer mandate, while ignoring the significant benefits that many businesses will receive as a result of the President's plan. Aside from cost control measures which will benefit both employers and workers, the plan calls for a cap on employer premium contributions of 7.9 percent of payroll. Many businesses who provide health insurance to their employees currently pay more and stand to gain a windfall under the plan.

The President's proposal also calls for a lifting of the heavy burden on businesses competing in the global marketplace by subsidizing the crippling costs of early retiree health care coverage. Most of our major international competitors spread the cost of retiree coverage across their entire population. We must follow the same path if our products are to be competitively priced and our domestic productivity is to be enhanced.

Some members of Congress are suggesting that the Clinton plan is financing reform on the backs of small businesses, part-time workers and service industries. The truth is that the majority of small businesses already provide health care coverage to their workers and are among the biggest winners under the Clinton plan. They will benefit from large group purchasing, from the elimination of cost-shifting, and from the generous subsidies that will be made available to them. The U.S. Chamber of Commerce, which counts a large number of small businesses among its membership, is backing the idea of an employer mandate.

Part-time jobs will not be eliminated by an employer mandate. It's true that employers would no longer have an incentive to hire part-time, temporary, or contract workers simply to avoid paying for health care coverage. But the plan isn't biased against part-time work either since premiums are pro-rated for part-time workers.

Opponents of the President's plan have predicted that the employer mandate will lead to huge job losses. The truth is that many more jobs are at risk if we fail to enact reform legislation. A recent study by the Economic and Social Research Institute examined the cost of reform versus the cost of the status quo. Under a set of intermediate assumptions, the study predicts that the U.S. will save \$1.2 trillion over the next decade if the health care system is reformed as President Clinton has proposed, rather than allowing the system to continue along its current path. These savings will benefit workers and businesses alike and will lead to greater job creation over the long run.

The President has wisely declined to make taxation of health benefits a major part of his proposal. Union members have suffered real wage losses in recent years as they have struggled to maintain their current level of health care benefits. While union members will be asked to contribute through the taxation of some supplemental benefits, the plan provides a period during which wages traded off for health benefits in recent years can be built back.

The special concerns of health care workers must be addressed as part of national reform. Any cost containment strategy must ensure fairness for health care workers and seek to minimize worker displacement. Funds should be provided to retrain insurance and health workers to match skills to health care sectors that have expanded service needs, using appropriate providers, settings and delivery arrangements.

We continue to believe that nothing short of full scale restructuring will solve the current crisis of the health care system. The AFL-CIO will continue to oppose proposals for change that rely on uncontrolled market forces or on incremental measures. Such measures will only serve to delay comprehensive reforms.

President Clinton's initiative, and his political commitment to health care reform, offers the best hope for achieving our long sought goal of universal health coverage. We intend to defend President Clinton's proposal against those who will advocate that we move more slowly, make incremental changes, or simply endure our current situation. We are committed to spearheading a coalition of consumers, senior citizens, businesses (large and small), community groups, and progressive providers to fight against those special interest groups defending their financial stake in the status quo.

Once again, I want to thank Chairman Stark and the other members of the subcommittee for this opportunity to testify. We look forward to working with you to make President Clinton's vision of "Health Care That's Always There" a reality for America's working families.

Chairman STARK. Thank you very much.

I was looking at your testimony and then thinking back to what you said. You tend to favor the CalPERS operation, did I hear that right?

Mr. SWEENEY. We think that there is a lot of good in the CalPERS operation that should be looked at very closely in the whole legislative process that we will be going through.

I might add that we have an extensive study on the CalPERS experience and managed competition and we will be glad to submit that.

Chairman STARK. Yes, I would like to see it. I think it gets mixed reviews. I have said this often, and I would ask you in all sincerity, CalPERS works without an alliance, does it not?

Mr. SWEENEY. Yes.

Chairman STARK. What I keep looking around for is somebody who says, I really insist that we have those alliances. I am not so sure that that is being disloyal to the President's plan, because as I look through it, it works without the alliances. You do everything that he wants to do without turning it over to Governor Wilson, in this particular case, or Governor Richards, if you wanted to do it in Texas.

Would it trouble you if they weren't in the plan but the other features were?

Mr. SWEENEY. If CalPERS were not in the plan?

Chairman STARK. No, if the alliances weren't, but the other features, if they were allowed to be created, as CalPERS is. There is now a HIPC in California that the Governor created. There are a variety of plans. There is a plan in Hawaii that is very extensive. There is a plan in the State of Washington, and in Wisconsin.

In your early deliberations in looking at this, were the alliances something that you really felt were essential to health care reform?

Mr. SWEENEY. I don't think the alliances are essential. The alliances are the proposal that the President has come up with. We have argued for treating the public sector the same as the private sector, with the assumption that whatever the structure, they will be complying with all of the major qualities that are necessary for national health reform, cost, access, quality, and so on.

Chairman STARK. The only reason I bring that up, Mr. Sweeney, is that I can see some problems in trying to get 50 States to create almost similar or identical organizations in their states and having them interpret laws that we will write, and there will be a further interpretation.

I see nothing wrong with what goes on in California or what goes on in a variety of States where they are trying to do it. I just look at that as a question to raise. There has been some suggestion, where the insurance industry has said they will be excluded. CalPERS technically would not be able to exist under the alliance program that the President has suggested. I think that could be changed.

There would be a new subsidy, as you mentioned, for retirees over 55, and it would be a big benefit for major corporations, largely those with older employees. The younger employees or those with less generous-bargained pension benefits would not share as well, but it would be a large cost.

We can remember the issue of \$200 to \$400 billion of unfunded liabilities for unfunded retirees' health benefits. The President has said they would recapture some of it. As I read it, he is saying 50 percent for 3 years, and where the liability is 10 years, that comes out to recapturing more like 15 percent of the liability rather than 50 percent.

My question is, would you support recapturing a larger share, say 50 percent of the full benefit, to be used for further health care benefits for other employees?

Mr. SWEENEY. In addition to the retirees?

Chairman STARK. No. For instance, if we relieve these corporations of their responsibility of their retirees' health care benefits, they will save, let us say \$10 billion a year, just to pick a number. The President is suggesting we take half of that savings for 3 years. I submit to you that is 15 percent of the total cost over a 10-year period.

Where I learned to bargain, you very seldom—I will bet you never do—start below half for your first offer. I am just suggesting, why shouldn't we say we will have those corporations give us 50 percent of the savings to be used for other employees' benefits, lower-income employees and others, rather than basically just for 3 years.

Would you have any objection to our getting a little more of those savings back to be used for health care for others?

Mr. SWEENEY. I would have no objection to getting more of the savings back, but I think that in fairness to the President's consideration, the President's proposal, the whole retiree issue is such a complex and widespread consideration that we have to look at all of the various factors.

Chairman STARK. The President's plan has been modified, and it now includes a cap on the Federal entitlement for subsidies for low-income workers for small businesses and these early retirees. It doesn't cap the benefits to the big corporations. They get that up front, the minute we take over the responsibility.

How do you view that? Isn't the impact of this decision on your members, particularly those in the lower-income working jobs, pretty tough? If the State doesn't make it, the State alliance runs out of money, they have to come back here for an appropriation on a State-by-State basis. You have to get the 49 other States to support the State that goofed up. Does that concern you?

Mr. SWEENEY. I think that we have to recognize the fact that small business has problems peculiar to the size of those businesses and that they require, certainly in the early years of the transition, some special attention. I think that the President's combination of proposals directed to that area are an indication of how serious the problem is and we should find some means of addressing the small business problem.

Chairman STARK. OK. Of course, remember that is not only small business, it is also for the poor, for those who are unemployed, who are just out of the system.

It is no secret that I have tended toward a single payer or a Medicare for all system, but after you heard the discussion at the beginning of this hearing, I can't hang just on one plan, I have to be flexible.

But I have suggested, as a way to be flexible, if there are all these plans or whatever out there, that this subcommittee has the option to compete as well.

Would you object if in every alliance and in every nook and cranny of this country your workers or your unemployed prospective workers had the option, at no cost to the Federal Government, to purchase Medicare for themselves in competition with Aetna or Blue Cross or anybody else? Would you object to letting us compete right alongside with everybody else?

Mr. SWEENEY. No, I don't think so.

Chairman STARK. Thank you.

Mr. Thomas.

Mr. THOMAS. Thank you very much, Mr. Chairman.

Mr. Sweeney, based upon the sensitivities of some folks, I need to understand what you said so that I won't be accused at a later time of misrepresenting your position.

Did you respond to the chairman's question by saying that you didn't think alliances were necessarily essential in the President's plan? Was that what you said?

Mr. SWEENEY. The chairman was referring to the CalPERS system.

Mr. THOMAS. No, the chairman's comment was the structure of the alliances, and it was whether or not you thought they were essential to the President's plan or that we could meet the need, similar to CalPERS, and allow it to exist if the alliances weren't in the President's plan. I thought your response was that you didn't think the alliances were necessary, but that's why I wanted to ask the question.

Do you believe the alliances are essential and a necessary part of the President's plan, or that they are, in part, a redundancy and a layer that could be eliminated without destroying the President's plan?

Mr. SWEENEY. No, I think that the alliances are a major factor in the President's plan and are necessary for the success of that plan.

Mr. THOMAS. OK. So you believe that the alliances are essential to the plan. That wasn't what I understood. It is a good thing you clarified that, because that isn't what I got out of your first statement.

On page 1, you indicate that your members have fought hard to hang onto their insurance, that they have faced greater out-of-pocket costs, declining choices as employers have tried to restrict where and when they can see their family doctors.

Are you saying that employers, in an attempt to curb costs on health control, have attempted to limit access of your members, or have they moved toward plans which limit access of the rank and file?

Mr. SWEENEY. Either way, they have limited the access.

Mr. THOMAS. They have gone to things like HMOs rather than fee-for-service structure?

Mr. SWEENEY. That is correct, yes.

Mr. THOMAS. Isn't that an essential component in the President's plan as well?

Mr. SWEENEY. The President's plan provides for choice.

Mr. THOMAS. The primary way the President and the First Lady have been representing their structure is that the alliances will rely heavily on new structures and their HMOs, primarily, which will, in fact, limit choice.

Are you saying that the President's plan does not restrict fee-for-service choice any more than the current arrangement today?

Mr. SWEENEY. That is what I am saying, yes.

Mr. THOMAS. OK. Maybe we all need to spend time with those 1,300 pages.

On page 2, you indicate that controlling costs of health care, in essence, produced a decline in real wages, since your first bullet is real wages would not have declined. The assumption is that real wages did decline over the period 1980 to 1993.

If there had been a fringe benefit deduction cap in place during this same time period, do you believe that real wages would have increased or decreased?

Since there was no fringe benefits cap and the negotiations between labor unions and employers were frequently over fringe benefits rather than real wages, had there been a cap on fringe benefit deductions, do you believe that the labor unions would have focused more on real wage increases and therefore there would not have been a decline in real wages, or would there have been a decline in real wages even if there had been a fringe benefits cap?

Mr. SWEENEY. No, I think that there would have been greater focus on real wages and they would have been more successful in raising the standard of living.

Mr. THOMAS. And then there would have been pressure on us to deal with the cap, because you couldn't pay for the health care costs under the amount that the government had allowed and we would have focused on health care costs far sooner because we would have bumped up against the cap rather than leaving them open ended.

I happen to agree with you on that, and I think that was one of the real mistakes. We proposed a fringe benefit deduction cap in the early 1980s, but it was rejected.

Finally, Mr. Sweeney, you indicate in the third paragraph of the sixth page that opponents of the President's plan have predicted that the employer mandate will lead to huge job losses. The last sentence in that paragraph, "after certain structures have been put in place, these savings will benefit workers and businesses and the like and will lead to greater job creation over the long run."

Your argument basically is that the President's plan will not produce job loss in the short run and, in fact, will produce job increases in the long run. Is that essentially what you say there?

Mr. SWEENEY. Yes.

Mr. THOMAS. Would you please explain to me why your organization supports a plan which will raise the costs to 80 percent of all employers in the United States and arguing that, in fact, it will produce jobs when you are opposing the North American Free Trade Agreement, when the economy of Mexico is 4.5 percent of the United States—smaller than the State of Illinois—but argue that NAFTA is going to lose hundreds of thousands of jobs over the same period?

Don't you think there is a little incongruity in terms of the two positions, arguing that this massive new cost to employers on health care, which may or may not be needed, will not only not lose jobs, it will produce jobs, but that the concept of fair and freer trade with Mexico will produce hundreds of thousands of job losses?

Mr. SWEENEY. I don't agree with you.

Mr. THOMAS. I am sure you don't. I just think it rather incredulous to make the statement you make here, while at the same time you are opposing the NAFTA structure, based on the argument that it will cost hundreds of thousands of jobs.

The problem is, Mr. Sweeney, I don't think your organization can have it both ways. I think we need to look at the impact on the economy, not just in terms of NAFTA but in terms of a health care plan as well. I think we have to be sensitive on both sides of the coin and not argue on the one hand we are going to create jobs with an enormous new mandate on business, but on the other hand, we are going to lose jobs. Maybe we will lose jobs both ways; maybe we will gain jobs both ways. But to argue one way on one opportunity and another way on another makes it difficult for me to fully appreciate the argument of your organization presented by you.

Thank you very much.

Mr. SWEENEY. And I don't see the comparison between the two.

Mr. THOMAS. I am sure you don't.

Chairman STARK. Mr. McDermott will inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I just want to say, for the record, that I know in the settlement what Boeing employees did with Boeing, they took less money out of the company's till in order to protect their benefit package, rather than taking cuts in their benefit package and taking money in their wages. They were fearful about what was happening to their benefit package, particularly their medical benefits.

My concern is that a cap on the benefit package does not necessarily translate into more money in your payroll. I think people are worried about what is happening to their health care benefits.

My question is does your union have a feeling about the difference between a cap on premiums at 7.9 percent, as opposed to a payroll tax of 7.9 percent? Do you care which way the money is collected?

Mr. SWEENEY. We would probably prefer the payroll tax.

Mr. MCDERMOTT. Could you elaborate on that for me a little?

Mr. SWEENEY. In terms of the fairness issue, we think that probably the payroll tax would be the fairest.

Mr. MCDERMOTT. For small businesses, it would be better to have 9 percent of payroll than to have a 9 percent or an 8.9 percent premium cap is what you are suggesting then?

Mr. SWEENEY. Yes.

Mr. MCDERMOTT. Let me ask another question. Some people have suggested that plans by Mr. Cooper or by Senator Chafee may be the ultimate political compromise. Although I am not someone who supports that view, it seems to me that these plans do not provide universal coverage nor a way to really control the rate of growth.

I wonder if you have looked at those plans and whether you think that they would be acceptable to your membership.

Mr. SWEENEY. No, neither one of those plans would be acceptable to our membership. We think that there are good provisions in both of those proposals, but we do not think that the enactment of either one would truly provide systemic reform of our health care system and would not provide universal access to the extent that the President's proposal does.

Mr. McDERMOTT. So you are basically agreeing with what the President said yesterday, that he would veto a plan that did not have universal coverage in it?

Mr. SWEENEY. I hope so.

Mr. McDERMOTT. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin will inquire.

Mr. LEVIN. I am tempted to let you answer at greater length Mr. Thomas's inquiry about NAFTA, but I will resist that.

Mr. SWEENEY. There are a couple of speakers after me that I know are going to cover that territory.

Mr. LEVIN. NAFTA is seeping into every discussion. Maybe that is good.

Mr. Sweeney, we all know that within the AFL-CIO there have been some differences of approach on health care. Let me just ask you to describe, just in kind of basic terms, why the organization has been able to find sufficient common ground in the President's proposal. I think there is a broad base of support within the organization for the President's proposal, is there not?

Mr. SWEENEY. Yes, there is.

Mr. LEVIN. In kind of short terms, how has that been accomplished?

Mr. SWEENEY. We think that the President's proposal is a proposal to have comprehensive health care reform. It is not a band-aid approach. There are many of us in the labor movement who have supported the single-payer proposals. We think that the President's proposal is a proposal that the Congress can adopt and that can bring consensus, as well as consensus all across the country in terms of business support and labor support, as long as the basic principles of cost, quality, and access, as well as progressive financing, are a part of the total package.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Sweeney, can you tell us what the average percent of payroll paid for health benefits for companies that employ most of your members is?

Mr. SWEENEY. In the case of our own union, we are diversified in terms of being public sector-private sector. We probably would estimate that it would be somewhere in excess of 10 percent.

Mr. MCCRERY. So it exceeds the 7.9 percent cap that the President has imposed in his plan.

Do you fear, in the President's plan, rationing of health care in the future?

Mr. SWEENEY. No.

Mr. MCCRERY. No? The average company that employs your members spends in excess of 10 percent, and I think some of them as high as 20 percent, of payroll for health benefits and the President has said that he is going to cap the entitlement, which not only includes the small business subsidies but also includes the subsidies for companies who bump up against the 7.9 percent cap. As you know, the companies are only obligated for 7.9 percent of payroll, and after that, I presume, the government pays the balance.

It seems to me that if you are going to cap the entitlement or the subsidy that the government provides for that and you squeeze that down, as we have with so many other government programs over the years, and that you are not going to allow companies to spend much in excess of 7.9 percent of payroll for health benefits, and therefore, I don't see how you reach your conclusion that your members, at least, are not going to have lower health benefits than they now enjoy. Can you explain that?

Mr. SWEENEY. Every other industrialized nation has been able to do it. We should certainly——

Mr. MCCRERY. Every other industrialized nation has been able to provide full health benefits with no rationing? Is that your statement?

Mr. SWEENEY. Have been able to provide——

Mr. MCCRERY. Full health benefits with no rationing?

Mr. SWEENEY [continuing]. Universal health care, comprehensive benefit packages, and hold the costs down at the same time.

Mr. MCCRERY. But don't they do that, sir, by rationing health care? Isn't that exactly how all these other nations do control their costs?

Mr. SWEENEY. They are not rationing health care, they are providing comprehensive health benefits.

Mr. MCCRERY. Isn't it true that many of those nations impose limits on the utility by their citizens of the health care system? For example, after a certain age, people are not qualified to receive heart operations. That is rationing care. Do you deny that those limits exist in those countries?

Mr. SWEENEY. No, there are some countries that do limit some benefits.

Mr. MCCRERY. Most of us would call that rationing.

Mr. SWEENEY. In our own country, we have to have the political will to provide the benefits that the citizens of our country require and want. If other countries have the political will to do it, why don't we?

Mr. MCCRERY. The fact is that we, in this country, are providing more health benefits to more of our citizens than most other countries in the world. So what we are proposing here under the Clinton plan, I think, is evening out health care benefits for everybody in the country, but in effect, lowering the total level of health care benefits that most of our citizens enjoy now, including your members, I would submit. And I would think you would want to look at that.

Given entitlement cap, I can see no other conclusion that eventually companies will be constrained to providing health benefits that do not exceed by much 7.9 percent of payroll, and that would mean

that most of your members, sir, would be getting medical benefits lower than that which they currently enjoy.

Chairman STARK. Mr. Kleczka will inquire.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Sweeney, as we all know, the President's plan would provide for universal coverage for every American, and as you compare that to the other plans that have been introduced, that is one of the unique portions of the President's proposal. The other plans, I think with the exception of Cooper, all try to resolve the health care crisis in the country by providing for medical IRAs.

We had a couple of panels of physicians testify before the committee a couple of days ago, at which time many of those physicians also supported having people set up medical IRAs. When the need arises, you go to the bank or to your IRA and pay for your health care costs.

I have a real problem with that, because it seems that when we have a situation or a problem in this country, we seem to be resolving it all with IRAs. For first-time home buyers, when they don't have the money for the down payment, there are those of us who would like to have a first-time home buyer IRA. For those who have a problem sending their kids to school, we want them to start slugging away money for an educational IRA. Now we are going to set up another one called a medical IRA, in addition to the retirement IRA.

At some point, it seems to me that the working Americans are going to run out of income to slug away in all these IRAs, so maybe you could give me your opinion of resolving this crisis with one more IRA.

Mr. SWEENEY. We need less IRAs and more comprehensive health care. The 37 million Americans who have no health insurance are not looking to an IRA to solve their health care needs.

Mr. KLECZKA. And the reason they are not looking to an IRA is because they have no means to put anything in it, is that one of the problems?

Mr. SWEENEY. That certainly is.

Mr. KLECZKA. One of the portions of the bill which we are probably going to talk about a lot over the next few months is the early retirement provision. I am trying to decipher whether or not that has been changed in the President's bill. Looking at the little booklet we received, it doesn't seem to be changed from the original proposal, unless you know something different than that.

Has there been a change in this final product?

Mr. SWEENEY. We are not sure, because it is really not specified, but we would like to check that out and get back to you on it.

Mr. KLECZKA. The problem I have is that the original proposal, and if I am correct, it is probably the same in the bill, is that upon retirement at age 55 to 64, the employer's responsibility would be reduced to zero and the Federal Government and the taxpayers would be asked to pay 80 percent of the health care benefits for the early retirees, with the retiree, him or herself, paying the 20. It seems to me that the major beneficiary of early retirements is the employer.

Would you object to a phasing-out of the employer responsibility similar to an example of early retiring at age 55, the employer

would pay 80, the employee 20. At 56, the employer would pay 70, and keep going down, with the employee held to a consistent 20, and then the pick-up would be at the Federal Government end?

Mr. SWEENEY. I really think that we should support the President's proposal on this. I would be glad to look at something—

Mr. KLECZKA. I would like to support all the proposals of the President but know full well one of the charges of the committee, we have to make sure this adds up at the end of the day. The early retirement thing, I am told, is a \$6 million cost item, which is growing.

I think if, in fact, we are going to produce or pass something along the lines of what the President wants, we have to make sure it is fiscally sound. I think some of these areas like the early retirement have to be relooked at and maybe let the employer, on a phaseout basis, help pay, versus shifting those costs to the taxpayer.

It is kind of unique in my mind that the taxpayer, the working Americans, will have to not only pay for their own health care but pay for 80 percent of the early retiree. Using the example I used the other day of the person who is a middle-management type of person with a decent early out benefit, he is fishing and golfing all day while his neighbor is working to pay 80 percent of his health care, and I don't think that is going to sell on the streets of this country.

Mr. SWEENEY. And I think that your proposal should be looked at in terms of the whole consideration on the retirees issue.

Mr. KLECZKA. Thank you very much.

Mr. McDERMOTT [presiding]. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Mr. Sweeney, can you tell us what the average contribution of the membership of your union to your present health care plans' premiums, deductibles, and copays would average out to be, per union member, per year? Do you know that off the top of your head?

Mr. SWEENEY. That is a tough question to answer because of the wide range of differences in different industries, different—

Mr. GRANDY. How big is your membership? How many unions have you got?

Mr. SWEENEY. Under the membership of the AFL-CIO?

Mr. GRANDY. No, you are president of the Service Employees International Union. I was really asking you to concentrate on that.

Mr. SWEENEY. And I chair the AFL-CIO Health Committee.

Mr. GRANDY. OK, but in that particular union—I wouldn't ask you to go AFL-CIO-wide—but in your experience as the President of the Service Employees International Union, can you give me an idea of what your employees on average pay annually for their health care plans?

Mr. SWEENEY. In our union, there is also a wide range, from the highest, most comprehensive packages to basic levels of benefits.

Mr. GRANDY. Let me put this another way. Are there many members of your union that pay nothing for their health care plan? In other words, they have negotiated a 100 percent employer payment?

Mr. SWEENEY. That is correct.

Mr. GRANDY. And then that would go out to about what level of employer payment, would you guess? What would be the greatest share for a Service Employees Union member to pay for his or her annual health care? Twenty percent, let us say, 10 percent? I am just trying to get an idea of what the contribution would be.

Mr. SWEENEY. We have hundreds of thousands of members whose health care package is completely paid for by the employer.

Mr. GRANDY. Yes.

Mr. SWEENEY. We have newly organized groups of workers where we are negotiating first or second contracts, where the worker themselves would be covered and not the family.

Mr. GRANDY. Is it a fair statement to say that, by and large, the majority of your union members are getting 100 percent of their benefits paid by the employer, or 90 percent? Do you have any idea what the employer-employee cost share would be?

Mr. SWEENEY. I would say that, in some way or another, most of our members are paying some portion of their health coverage.

Mr. GRANDY. You wouldn't be able to kind of estimate a percent at this point?

Mr. SWEENEY. If I were to take a stab at a percentage, it might be in the range of 15 to 20 percent.

Mr. GRANDY. OK. That is all I wanted to ask. So we can conclude you are paying around 15 to 20 percent.

Going back to something that Mr. Kleczka raised on the early retiree benefits, the number and cost for that proposal has floated somewhere between \$6 billion a year to five times that amount. I understand, obviously, that you are a supporter of that particular portion of the package, as well as, I assume, the extension of ongoing company and union plans that are more generous than what the President's package envisions, and they would be allowed to continue, I think, still for 10 years under the plan.

You support that provision, too, as well?

Mr. SWEENEY. Yes.

Mr. GRANDY. I think Mr. Kleczka has raised some important points, and I think that will be, at least one of those areas, possibly both of them, will be items in dispute in this committee and probably in Congress.

If those two provisions were deleted from the final version of the President's package, would your membership still support the President's bill, absent early retiree benefits paid for by the public sector and a corporate union period of grace for the plans that you currently have in play?

Mr. SWEENEY. We would have to see what the total proposal was before we could start making decisions on what we would support or not support.

Mr. GRANDY. So clearly, that would influence your decision, then. If those two items all of a sudden disappeared, you would have to go back in and take a look at whether or not your association, your unions could really embrace this as enthusiastically as you do right now?

Mr. SWEENEY. Sure.

Mr. GRANDY. OK. Thank you, Mr. Chairman.

Mr. McDERMOTT. Mr. Hoagland will inquire.

Mr. HOAGLAND. I just have a couple of brief questions, Mr. Chairman, following up on Mr. Kleczka's and Mr. Grandy's comments about early retirees.

Mr. Sweeney, it seems to me that there are three concerns I have with the early retiree provisions. First, it is regressive, in that you are taking a huge obligation owed by major corporations and smaller corporations in America and spreading them out among the general populace.

Second, the underlying rationale is to make our large corporations more competitive, but many of our competitors offer a larger, wider panoply of benefits than we do here in America. I have heard it said that industry in Germany offers 60 percent more in terms of benefits than American industry does, and that being the case, I wonder how persuasive the competitiveness rationale is, given, I assume, other European countries offer a greater range of benefits than American companies do as well.

Finally, it is just going to add enormous costs to the legislation. I wonder if you have any thoughts or observations that might enlighten us as to whether, in your view, the regressive impact of this is justified, the added cost is justified, and the rationale for it is basically sound.

Mr. SWEENEY. While we can look at other countries' experiences and how other countries have addressed these issues, we really have to focus on where we are today in terms of a private-public health care system and have to find a total proposal that is going to address all of the various major considerations.

The retirees' issue is a big issue in our country and has very serious effects on different industries in different ways. We should be looking at a means to address the retiree health problem and put it in terms of the total package of health care and also find some way of financing and addressing the cost issue as well.

Jerry Shea from the AFL-CIO might have a little bit more experience in terms of this issue.

Mr. SHEA. Congressman, there has been a lot of question raised about this proposal, and as president Sweeney has said, it is a key part of what is the total proposal, obviously. I think you have to look at it in that light.

But in that light, we see it as a very strong component of the proposal because it treats a very serious problem in what we see as being a very fair way and has the additional benefit of providing some relief in a needed economic area in the country.

There are other ways that this could be dealt with, obviously, but in this context, it seems like a very balanced way to do it.

Mr. HOAGLAND. Let me ask a question on a different subject. The plan has been criticized for offering a basic plan that is a Cadillac version when a Ford would do. I wonder if you all have thought through whether we might do better to start out with a basic plan of benefits that is not quite as rich as this, on the theory that a plan as rich as this is going to cost enormous amounts.

Second, we can always add benefits later if it becomes apparent that they are needed and justified, but we can't really very effectively take benefits away once they are granted.

I wonder if AFL-CIO has had an opportunity to consider the issue of whether a basic benefits plan that is not quite as rich would be acceptable.

Mr. SWEENEY. We don't look at this as a very rich benefit package or as a Cadillac plan. We could certainly have some discussion in terms of the comprehensiveness of the benefit package. To us, it is a basic minimum package, really, in terms of total health care. It also does phase in some improvements over the period of time and does focus initially on some of the problems affecting children and the elderly, but over the long term is moving toward a good core package of benefits.

I think that the medical associations and others who have expertise in this area would agree that it is a good basic, minimum package.

Mr. HOAGLAND. Thank you, Mr. Sweeney, for your thoughtful testimony.

Thank you, Mr. Chairman.

Chairman STARK. Are there other members who would like to inquire?

John, would you bear with me just 1 minute? I don't mean to beat a dead horse here, but I want to make sure. I know that Congressman McDermott asked you about your preference as to the payroll tax or the premium as a way to collect the funds for whatever we are able to do, and I share your feeling. I read that part of the bill last night, and going through the premium through an alliance requires almost every worker to basically fill out a second income tax form. It gets rather complex.

I would like to ask that question again, pointing out, and I don't mean to mislead you here, that there would be some jurisdictional differences. If, in fact, it were a premium, then a good bit of the administration would fall to the Department of Labor.

Let me ask you that question again. We might, and I am sure Mr. McDermott did not have this jurisdictional interest there because I think you can make the case on simplification and other things, but just having said that, the jurisdiction would be less in the Labor Department and probably more in Health and Human Services, would you still feel that a payroll tax would be a preferable way to collect the revenue, rather than some kind of a premium collected by the State or Federal Government?

Mr. SWEENEY. I believe so, yes.

Chairman STARK. I do, too, but that is an inside issue for us. I know that you have excellent relationships, and we have an excellent Secretary of Labor and I don't mean to get into that. That is not my battle. That is the administration's battle, as to who is going to administer this, but I appreciate the answer. I just wanted to make sure that you were aware of that.

I appreciate your candor and I appreciate the trouble you must have taken to become so familiar with 1,300 pages of complex legislation. If you stayed up as late as I did, you probably got through twice as much as I did, plus I think you read it more carefully.

We will welcome your counsel and the counsel of your staff, who are always here to help us when we need them. We appreciate your interest in this concern and I am sure we will have a lot of areas in which we will work together over the months ahead.

Thank you very much.

Mr. SWEENEY. Thank you very much.

Chairman STARK. Our next witness is Gerald McEntee, the international president of the American Federation of State, County, and Municipal Employees, affectionately known as AFSCME. We welcome you to the committee. My notes suggest that I should ask you to testify in the order in which you were introduced, which is first.

If you would, please identify your colleagues for the record.

STATEMENT OF GERALD W. McENTEE, INTERNATIONAL PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES, AFL-CIO; ACCOMPANIED BY CHUCK LOVELESS, DIRECTOR, DEPARTMENT OF LEGISLATION, AND ROB MCGARRAH, DIRECTOR, DEPARTMENT OF PUBLIC POLICY

Mr. McENTEE. Thank you, Mr. Chairman.

On my left is Chuck Loveless, our director of our Department of Legislation, and Rob McGarrah here on my right, the director of our Public Policy Department.

Two years ago, when the health care debate really started in true earnest, he was six-foot-four. You can see now today this man is only about five-foot-ten. It has been tremendously difficult on Mr. McGarrah.

Chairman STARK. Mr. McDermott and I were 10 feet tall, and we had a good basketball contract lined up. [Laughter.]

Mr. McENTEE. Mr. Chairman and members of the committee, I am Gerald W. McEntee, President of the American Federation of State, County, and Municipal Employees, affectionately known as AFSCME. We would like to thank you for the opportunity to testify about President Clinton's plan for national health care reform, the Health Security Act of 1993.

As the leader of the nation's largest union of public employees and health care workers, with 1.3 million members, we want you to know that there is no more crucial issue before you than health security for all Americans.

Working in hospitals, clinics, and welfare and budget offices, our members see the results of America's failed health insurance system every single day. No matter how hard they and their mayors and Governors try to give people the care they need, the costs won't stop piling up.

States and cities, hospitals and doctors, businesses, large and small just can't solve the problem by themselves. It is time for Congress to do its part and pass comprehensive health care reform.

Like you, Mr. Chairman, and others, we have been critical of managed competition. The President's plan would, in certain respects, we believe, promote it. However, unlike the bill sponsored by Congressman Jim Cooper from Tennessee, the President prevents the kind of managed competition that would deny coverage to millions of Americans. He requires an employer mandate, and that is the linchpin to any form of national health care.

For years, AFSCME has favored a single-payer plan, because it is the most simple and efficient way to provide health security for all Americans. We continue to strongly support this proposal and

will work with the Congress and the administration to ensure that the principles of single payer are incorporated into the plan.

We do commend the President for his bold leadership. He has proposed a health security plan that guarantees insurance to everyone and uses the power of the Federal Government to organize the financing and structure of a new health insurance system.

The main problem with the system we have today is there is no budget and health insurance companies are free to cherry-pick the healthiest people to squeeze out the most profit from the system. We believe we all have to be in the same system. Otherwise, the sickest people can't get insurance, costs skyrocket, and we are right back to the mess we have today. The President proposes to fix the problem with regional health alliances, covering nearly everyone.

Public employees will do their part to make those alliances work. We are willing to select our health plans from them, as long as they cover almost everyone in the region. We believe that is in the public interest.

But if Congress gives in to special interests and allows employers with fewer than 5,000 employees to get out of the alliances, to make their own deals for health insurance, we're right back to the cherry-picking problem. We are against that and we won't support it. That is not comprehensive health care reform.

Equally important, Mr. Chairman, is the President's requirement limiting the cost of the employer-mandated premium. As proposed, the employer premium for the private sector is capped at 7.9 percent of payroll. For Federal, State, and local governments, the cap will be effective 4 years after enactment. It is very important that this cap apply to State and local governments. Otherwise, State and local governments would be held liable for any cost overruns incurred by any alliance.

We will continue to work with the Congress and the administration to guarantee the same cap and equal treatment for the public and private sector. Anything less would violate the budgetary discipline essential to the success of the plan.

While we strongly support much of the President's proposal, there are several key areas of concern to our membership. We are concerned that the President has decided to cap subsidies for low-income individuals. If we are to achieve true health security, then subsidies must be available to all who need them.

In addition, it is absolutely critical that the enormous changes that are proposed in the President's plan do not harm the workers in our health care delivery system. The President's system would integrate the public and private mental health and mental retardation delivery systems into a single system in each State. Public and private hospitals will undergo major transformations as the plan for managed competition becomes effective. As you know, in anticipation of the President's plan, hospitals and HMOs already have escalated the pace of their mergers and consolidations.

Most of these changes may be necessary and unavoidable. But one thing is clear. It is essential that the bill adopted by Congress recognize the experience and commitment of these workers and that they be utilized in the new delivery system. Health care worker protections must be included in the plan. They are essential to its success and successful to AFSCME's support of the plan.

We have various other concerns, which we would like to make part of the record. As we work with you and as we learn more of the details of the President's plan, we will bring these issues to your attention.

Mr. Chairman, the time for national health security has finally come. We are privileged to be able to work with you and the administration to make comprehensive health care reform a reality for all Americans.

Thank you.

Chairman STARK. Thank you very much.

Because we share so many opinions, I won't spend a lot of time on the substance of your remarks, with which I agree wholeheartedly. Let me talk a little bit about procedures.

I guess in my next career, maybe I ought to be a negotiator for union contracts. I feel I am getting whittled away here, and I think I am maybe learning something.

The Postal Unions got a pass, right? They got out of the box.

There has been an attempt to ameliorate one of your concerns by saying the cap on the employer contributions will end in the year 2002.

Mr. MCENTEE. Yes.

Chairman STARK. Does that satisfy you, Mr. McEntee?

Mr. MCENTEE. No.

Chairman STARK. Me neither, and don't sell out for 2001, OK? [Laughter.]

Mr. MCENTEE. We are all negotiators.

Chairman STARK. The other thing that is happening, and I would ask you to stay with us, is it is my understanding that last night, there was a call from a White House staff to one of your member groups, suggesting that that particular group would get an exemption and be allowed to be in the alliance if they would speak up and help support the alliances. My recollection of the mandate of organized labor is you hurt us one, you hurt us all, and that if there is going to be that kind of exemption made, it ought to be made across the board and not by cherry-picking various groups.

Would you stand with me on that message to the White House?

Mr. MCENTEE. Yes. We would call that cherry picking, too. I know I didn't get the call.

Chairman STARK. I know you didn't. All we ask here is we will do our best to negotiate with you and among ourselves to get a bill, but it is very hard to do that when somebody is off negotiating at another level, cutting deals that we are not privy to. In face-to-face negotiation, we will do just fine, thank you, and we will try and help you.

I appreciate your willingness to stick with us. It is going to be tough to get 218 votes to get a bill that we can all agree brings universal coverage to everybody in this country.

Mr. MCENTEE. That is right.

Chairman STARK. We are dedicated to doing that, and I appreciate your willingness to stick with us on that.

Mr. McDermott.

Mr. MCDERMOTT. Mr. Chairman, I would only echo your remarks.

I think your testimony, Mr. McEntee, is sort of music to my ears. We would not, in the single-payer coalition, have gotten as far as we had had we not had the support of your union and others like you. I want to publicly say thank you, and we will count on your support to hold firm. We need you to anchor this whole thing.

Thank you for coming.

Mr. MCENTEE. We thank you for your leadership, both you and the chairman.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. McEntee, you indicated that the revised version and the final version of the President's proposal does contain a cap for public employers. I am unclear as to what you indicated in your remarks, because you indicated that the cap would be 7.9 for States and cities for all medical expenditures. My reading and understanding is that the 7.9 percent cap only applies to the health care coverage for the public employees working in that political subdivision.

Could you maybe correct me if I am wrong?

Mr. MCENTEE. No, I think you are correct.

Mr. KLECZKA. OK.

Mr. MCENTEE. It is for the workers. Yes, you are correct.

Mr. KLECZKA. You indicated that you didn't want other costs shifted to the State and municipalities, and I am assuming the mayors and other officials would agree with you, but let us get it straight that the 7.9 does not cover and all expenditures, just that attributed to the public employees.

Mr. MCENTEE. Correct.

Mr. KLECZKA. Did you want to comment on the early retirement issue that has caused some of us to have some grave concerns?

Mr. MCENTEE. First of all, I think the early retirement issue, first of all, I think is good public policy. If you are talking about universal health coverage, you are talking about universal health coverage for all Americans, to provide them with that kind of security in their own minds and their own life, then I think you have to cover everybody and you have to cover early retirees as well.

But I would go one step further than that. I think it is good economic policy. We sit and you sit in committee, and we have all watched literally the down sizing and down structuring of State and local governments. We have also watched it in terms of our major corporations in America. General Motors, Ford, all of those major companies now have less workers than they have had for 30 and 35 years.

One of the methods that they try and use, that they try and use in terms of making the down sizing easier for the company, easier for the workers, is an early retirement process. One of the problems with using the early retirement process and its lack of success vis-a-vis down sizing is the fact of a fright, a fear in terms of these people that if they go out on early retirement, they lose their health care benefit, and they are scared to death—

Mr. KLECZKA. Yes, I agree with—

Mr. MCENTEE. Can I finish? They are scared to death about losing that.

Mr. KLECZKA. OK, but my problem with your argument is I agree they are scared to death about losing their health care benefits. Otherwise, early retirement would not be an option.

But my contention is that there is an employer responsibility here, because for the employer, an early retirement situation does save that operation some dollars. I think he or she who is running the company has some responsibility to at least pay part of the health care costs, knowing full well that if the worker is not going to be replaced, that is a savings, or if a worker is going to be replaced, it is one who comes in at a much lower salary level.

So to give this windfall to the employers and shift it to the back of the taxpayers, the people who have to stay working in the marketplace, reeks to me of being somewhat unfair. If I were a worker with my neighbor being retired, I would go and beg my employer for an early retirement and then I could sit and fish with him all day.

At the end of the year, we are going to find out there aren't enough people working to support this and there aren't enough smokers to produce that extra revenue, and so we are going to have a fiscal dilemma with this thing.

Mr. MCENTEE. If I understand the UAW contract, and they are here, for example, and they can speak for themselves, the employer has to pick up the employee's share, so that there is an employer responsibility.

It is my understanding also—I haven't read the bill, but that particular provision has a very long phase-in time span to it.

Mr. KLECZKA. No, my reading is that the actual year it phases in is 1998, so this being up on line in 1996, that is a short period.

Chairman STARK. If the gentleman would yield—

Mr. KLECZKA. Sure.

Chairman STARK. Let me interject here. It was a question that I directed earlier to Mr. Sweeney. I think it helps, I think we all agree that we should cover the early retirees.

Mr. KLECZKA. How?

Chairman STARK. The question is, there are big savings when we relieve these corporations of that burden. Now you can argue that those corporations did the right thing. For all these years, they have been paying pretty generous benefits, not out of choice, but because of good bargaining. But nonetheless, they have been paying while other corporations haven't, so I am willing to say they are entitled to some of the savings.

What we have to get is that fair amount that they should give back to help other employees, lower-income employees, the replaced employees, and how much we should let them enjoy these savings, because all taxpayers are giving it back to them. And I think that will be—

Mr. KLECZKA. And as the chairman pointed out, the provision of the legislation, and I think it is in the final product, would provide for a payback to the tune of about 15 percent, which is kind of meager, in my estimation.

Again, you have to think of the person out there who is going to be asked to not only pay their own 20 percent but the next fellow's 80 percent, and that is a problem that we are going to have to resolve here.

Thank you.

Chairman STARK. Thank you.

Mr. Hoagland.

Mr. HOAGLAND. That is interesting.

Mr. McEntee, I think we all appreciate your excellent testimony and the thoughtfulness with which you have approached it.

Do you have any ideas as to how we might make this early retiree thing work a little more cheaply? Could we introduce some additional need-based criteria, perhaps, or as my two colleagues have suggested, ask the corporations that are shedding this financial liability to contribute more?

My concern is the sort of standard one that everybody is talking about these days, and that is that the cost estimates of all of these programs have traditionally been grossly low. This is going to be an extremely expensive program. We can always add the benefits later. Why don't we think of ways of making it as frugal and as inexpensive as we can?

It seems to me the early retiree section is a place to begin. Do you have any ideas as to how we could do it for less?

Mr. MCENTEE. No, we haven't given much thought about it, because we think, to a very large degree, that it is fair.

Most of these early retirees, by virtue of their negotiated contracts in terms of health care, have carried to a very large degree the health care system as it exists in the United States by virtue of the high premiums that they have paid for health care. That has enabled other people without health care the utilization of emergency rooms, for example, and to get some kind of health care, and that cost obviously has been shifted to people such as these.

I think it is also important to understand and realize that many of these early retirees that you were talking about, that these people in negotiating their labor contracts over the last 10 or 11 years have gone to the table and they have taken sometimes zero wage increases or 1 or 2 or 3 percent.

We constantly try to come to grips in this society, moving from high skill to low skill, high wage to low wage, and these kinds of folks in their negotiations have taken very minimum kind of wage increases in order to protect their health care benefits and protect their retirees in terms of their health care plans. I think you have to give them a little credit for that.

Mr. HOAGLAND. Clearly, as the President indicated yesterday, we have to measure all of these things against the current system, and the current system is working very poorly.

One of the major elements we are concerned about now is the early retirement lock problem. We don't want to discourage people from taking early retirement.

Mr. MCENTEE. Right.

Mr. HOAGLAND. I wonder if this doesn't go far, far beyond the needs of that problem. In other words, I wonder if we couldn't solve the retirement lock problem in much more modest, moderate reforms.

In that connection, if we entirely or mostly relieve corporations of this responsibility, then they will have incentives to push people out. We don't want to shift to a situation where bosses are pushing them out of the door as fast as they can.

Mr. MCENTEE. Of course.

Mr. HOAGLAND. We will have plenty of time to try and work out these details.

Thank you again for testifying.

Mr. MCENTEE. Thank you.

Chairman STARK. Thank you very much for your help this morning. We look forward to working with you as we try and achieve the very laudable goals in the President's bill. We appreciate your coming this morning.

Mr. MCENTEE. Thank you very much.

Chairman STARK. Thank you.

Chairman STARK. Our next panel is comprised of four members representing labor groups. I would like to welcome Mr. William Hoffman, the director of the Social Security Department of the United Auto Workers; Mr. Jim Ray, the counsel to the Building and Construction Trades Department of the AFL-CIO; Mr. Robert Chase, the vice president of the National Education Association; and Ms. Candice Owley, the vice president of the American Federation of Teachers.

I welcome you all to the committee, and I would ask you to proceed in the order in which you were introduced.

Mr. Hoffman, do you want to lead off?

STATEMENT OF WILLIAM S. HOFFMAN, PH.D., DIRECTOR, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE, AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, (UAW)

Mr. HOFFMAN. My name is Bill Hoffman and I represent the UAW.

Chairman STARK. Could I admonish the witnesses that this committee is way behind in its electronic wizardry and you have to practically swallow those microphones for our guests and our recorder to hear you, so if you get them up real close, it would help us much. Thank you.

Mr. HOFFMAN. Thank you, Mr. Chairman. I am here on behalf of the UAW and would like to thank you for this opportunity to present our views on President Clinton's health care reform proposal.

The UAW believes that the Clinton proposal is good for workers, good for employers, good for the entire country. We strongly support the President's proposal. It contains a number of basic principles which the UAW has long supported.

Universal coverage—the Clinton plan would guarantee comprehensive health benefits to all Americans. Everyone would be entitled to this coverage, regardless of income, health, employment status, age, or where they reside. The UAW has long believed that health care should be a basic right for all Americans. We commend the President for his courage in making this principle a central component of his proposal.

We are also pleased with the breadth of the guaranteed benefit package. Universal coverage is meaningless unless it includes the full range of family wide health services.

Cost containment—the plan would contain escalating health care costs through the formation of large purchasing pools, the stand-

ardization of claims forms, and the reduction of micromanagement. Most importantly, however, the Clinton plan would establish a backstop national health care budget that would gradually reduce the rate of growth in health care costs, both in the private sector and under Medicare and Medicaid. We strongly support the principle of enforceable health care budgets. We believe this is the only way to prevent health care costs from continuing to spiral out of control.

Level playing field—the Clinton health plan would establish a level playing field by requiring all companies to contribute to the cost of health care for their employees and by requiring health care plans to use community rating. This would eliminate cost shifting between employers. And employers and families would no longer be penalized just because their workers or members were older or developed a serious medical condition. The UAW believes as a basic principle that employers should not be forced to compete on the basis of their health care costs.

Retiree health care—the UAW strongly supports the provisions in the Clinton health plan dealing with early retirees between the ages of 55 and 65. We view this as one of the most critically important components of the President's plan. We have witnessed dozens of cases where employers have abruptly canceled or reduced health insurance coverage for retirees and their families. As a result, retirees are forced to live with drastically reduced living standards.

This tragic situation is caused in part by health cost escalation, competition from foreign companies which operate under national health care programs that distribute the burden of retiree health care costs across the entire society, as well as competition from younger domestic companies which have a much lower ratio of retirees to active workers and therefore do not have to bear the same burden of retiree health care costs.

The Clinton plan would guarantee health insurance coverage for early retirees just like the rest of Americans, and would provide for equitable financing by spreading these costs uniformly throughout society.

Limits on family costs—the UAW supports placing limits on the premiums and cost sharing which families are required to pay for health care. We applaud the administration's commitment to this principle. However, we urge the administration and Congress to consider lowering the cap on family premiums from 3.9 to 2 percent.

Tax cap—we commend the administration for preserving the tax-free status of most benefits. In rejecting suggestions that they should support a tougher tax cap on health care benefits, the First Lady has forcefully expressed the view that it would be wrong to subject 35 million Americans to a substantial new tax increase. The taxation of health benefits would result in a large tax on the middle class. It would also lead to a reduction in important health insurance coverage and it would not be an effective mechanism for slowing the growth of health care costs.

Mr. Chairman, in conclusion, we appreciate the opportunity to come before you and testify and look forward to working with you and the rest of the committee in the future.

[The prepared statement follows:]

**STATEMENT OF WILLIAM S. HOFFMAN,
DIRECTOR, UAW SOCIAL SECURITY DEPARTMENT, INTERNATIONAL
UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT
WORKERS OF AMERICA (UAW)**

Mr. Chairman. My name is William S. Hoffman. I am Director of the Social Security Department for the International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW). On behalf of the 1.4 million active and retired members of the UAW, I would like to thank you for the opportunity to present our views on President Clinton's health care reform proposal.

The problems facing the health care system in the United States have been well documented. There is now a broad consensus that prompt action must be taken to address the interrelated problems of declining access to care, escalating costs, and inadequate quality of care.

Mr. Chairman, the UAW believes that the plan presented by President Clinton would address these problems in a manner which is good for workers, good for employers and good for the entire country. The UAW strongly supports the President's proposal. We commend the President, the First Lady, and the entire White House health care team for their efforts in developing this package of reforms.

The UAW believes we now have an historic opportunity to achieve our long-held dream of a comprehensive national health care program. We urge Congress to support the President's proposal.

The health care reform proposal developed by the Administration contains a number of basic principles which the UAW has long supported. We would like to discuss each of these points.

1. Universal Coverage

The Clinton health care plan would guarantee comprehensive health care benefits to all Americans. Everyone would be entitled to this coverage regardless of income, health or employment status, age, where they reside, or other factors.

The UAW has long believed that health care should be a basic right for all Americans. We commend the President for his courage in making this principle a central component of his proposal.

The UAW is also pleased with the breadth of the benefits package which would be guaranteed under the President's proposal. Universal coverage is meaningless unless it includes the full range of health care services which are needed by families. The President's plan would provide most benefits which are now covered by major Fortune 500 companies, as well as additional preventative services. Certainly this is a far cry from so-called "catastrophic" proposals which have been floated in the past.

Although many UAW members already have comprehensive health care benefits under the collective bargaining agreements the union has negotiated with employers, our strong support for the Clinton program is not just a function of our commitment to the principle of universal coverage. Our members also have a strong stake in the achievement of this principle.

During the past decade thousands of UAW members have lost health insurance coverage after they were laid off. All too often this has happened in the context of plant closings and bankruptcies. At the same time, many UAW members have been forced to accept employer demands to cut back on health insurance coverage, including restrictions on dependent eligibility, increases in employee cost sharing and reductions in the coverage of specific benefits. And, especially since FASB promulgated its new accounting standards for post-retirement medical benefits, thousands of retired UAW members have been faced with

reductions in or the outright termination of their health insurance coverage.

The Clinton health care proposal would put an end to the trauma and tragedy associated with these assaults on the health security of UAW members. Under the President's proposal, their health care coverage could never be taken away. Like all Americans, our members would gain the security of knowing that their health care benefits will always be there when they are needed.

2. Cost Containment Through Enforceable Budgets

The Clinton health care plan would contain escalating health care costs through a number of mechanisms. The formation of large purchasing pools (the health alliances) would enable consumers to negotiate better rates with health care providers. Guaranteeing all families a choice of health care plans will force the plans to compete with each other by holding down costs while maintaining quality. And the standardization of claims forms and the reduction of micromanagement will help to eliminate a lot of the wasteful administrative expenses associated with our current system.

Most importantly, however, the Clinton plan would establish a "back-stop" national health care budget that would gradually reduce the rate of growth in health care costs, both in the private sector and under Medicare and Medicaid. In the private sector this budget would be enforced by capping the increase in premiums charged by health care plans. In the public sector this budget would be enforced by directly limiting federal expenditures under Medicare and Medicaid.

The UAW strongly supports the principle of enforceable health care budgets. We believe this is the only way to prevent health care costs from continuing to spiral out of control.

Throughout the last decade, escalating health care costs have strained the resources of families, businesses, and the federal and state governments. Tough cost containment measures are not only an essential prerequisite for overall health care reform. They are also essential to free up the necessary resources for other unmet social needs.

Despite the general consensus in support of cost containment, the notion of imposing overall budget discipline on the health care sector remains controversial. But common sense tells us that health care costs will never be brought under control if we continue to give the health care sector a blank check. Individuals, businesses, and the federal and state governments all use budgets to control their spending in other areas. If we can develop budgets to circumscribe spending in such complex and vital areas as national defense, surely it makes sense to use the same approach with respect to spending on health care.

Unless our nation adopts a health care budget, we will never establish the discipline which is needed to force health care plans and providers to seek ways of delivering quality care in a more efficient manner. Without budget discipline, plans and providers can always spend more to deliver the federal package of benefits; there will not be any incentive for them to seek ways to provide those benefits for less.

I want to stress, however, that the UAW's support for the imposition of budget limits on Medicare and Medicaid is contingent on the imposition of similar restraints on private sector health costs. Limitations just on public health care programs, as has been proposed by Senator Chafee, would be unacceptable to the UAW because this would inevitably lead to additional cost shifting from the public programs to the private

sector, and because this could undermine the quality of care provided under the public programs by further discouraging providers from participating in those programs. I also want to caution that any limitations on spending under Medicare and Medicaid must be accompanied by provisions that will assure access to quality care for persons covered under these programs.

3. Level Playing Field: Employer Mandate and Community Rating

The Clinton health plan would establish a level playing field with respect to the payment of health insurance premiums by requiring all companies to contribute to the cost of health care for their employees, and by requiring health care plans to abide by community rating in setting the premiums which are charged to companies and families for health insurance coverage. The UAW applauds the Administration for including this principle in its proposal. We believe the establishment of a "level playing field" would provide several important benefits.

First, it would eliminate the cost shifting between employers which currently takes place in our health care system. Employers that currently provide health insurance coverage to their workers would no longer have to subsidize employers that fail to provide such coverage. There would no longer be any "free riders". Instead, all employers would be required to pay their fair share.

Second, it would eliminate differentials in health care costs for families and employers based on health status or age. Employers and families would no longer be penalized just because one of their workers or members happens to develop a serious medical condition that requires expensive treatment. And they would no longer be penalized simply because they have older workers or members. Instead, the higher costs associated with sick or older persons would be spread broadly throughout society, with everyone sharing the burden of these higher-cost individuals.

Many of the companies with whom the UAW negotiates, including the Big Three automakers, are currently penalized because of the absence of a "level playing field". It is estimated that 15 percent of the Big Three's health care costs are attributable to cost shifting associated with the spouses of auto workers who are employed at other companies but do not have insurance coverage through their own employer. The Big Three automakers also have to shoulder health care costs attributable to persons who are currently uninsured. In addition, the Big Three automakers have higher health care costs because their workforce is generally older. As a result of all of these factors, the Big Three automakers and other manufacturing companies are placed at a significant competitive disadvantage with other employers. This creates tremendous pressure to cut back on health insurance coverage and has a negative impact on employment.

The Clinton health plan would eliminate these problems by establishing a level playing field for all employers and families. As a result, high risk individuals would no longer be penalized. And employers would no longer be forced to compete on the basis of their health care costs. They would not have to choose between cutting health care benefits or losing jobs.

The UAW believes as a basic principle that employers should not be forced to compete on the basis of their health care costs. And there should not be any discrimination between families based on health costs. Instead, there should be a level playing field, with all employers and families being required to contribute their fair share. Our country currently provides a basic level of retirement income to all individuals through the Social Security system, which is financed through equal contributions by

all employers and workers (i.e. the same percentage of payroll). The same principle should be applied to financing health insurance coverage for all Americans.

The UAW is concerned that under the Clinton plan the level playing field is phased in too slowly for large employers (those with more than 5000 that decide to opt into the regional alliances). Specifically, the benefits of community rating and the 7.9 percent of payroll cap on employer liability for health insurance premiums are only gradually phased in over eight years, with no benefits being provided for the first four years. The UAW urges Congress to consider a quicker smoother phase in, without any abrupt "cliff" after four years.

4. Retiree Health Care

The UAW strongly supports the provisions in the Clinton health plan dealing with early retirees between the ages of 55 and 65. We view this as one of the most critically important components of the President's plan.

Millions of early retirees do not have any employer-paid health insurance coverage. These early retirees are forced to rely on expensive individual policies, or else are left without any coverage. About two million early retirees currently do have employer paid health insurance coverage. But the security of this coverage has increasingly come under attack.

During the past decade, the UAW has witnessed dozens of cases where employers have abruptly cancelled or reduced health insurance coverage for retirees and their families. The impact of these cutbacks has been devastating, particularly for early retirees who do not have Medicare to fall back on. Often these early retirees cannot get replacement coverage because they are considered "uninsurable" by private insurance carriers. Even when individual policies are available, the cost is often prohibitive. Many of these individuals made their decision to retire based on the promise of continued health insurance coverage. When that promise is suddenly broken, it is too late for the retirees to start over again. As a result, their legitimate retirement expectations are dashed, and they are forced to live with a drastically reduced standard of living.

The UAW's experience with cutbacks in retiree health coverage is not unique. The same pattern has been repeated in countless situations across this country during the last decade.

A number of factors have been leading more and more employers to eliminate or reduce health insurance coverage for retirees. The continuing escalation of health care costs is certainly one important factor. In addition, many of the companies that provide retiree health insurance coverage - particularly older companies in the manufacturing sector - have been encountering growing competitive pressures to cut back on coverage for retirees. These employers face competition from foreign companies which operate under national health care programs that do a much better job of containing health care costs, and distribute the burden of retiree health care costs across the entire society. These employers also face competition from younger, domestic companies which have a much lower ratio of retirees to active workers, and therefore do not have to bear the same burden of retiree health care costs.

Health care costs for employers in Japan are approximately one-third the costs for employers in this country. This gives the Japanese auto companies a big cost advantage when they import cars into this country. In addition, the transplant facilities established by the Japanese companies in this country are relatively new. They have very few retirees. In contrast, the domestic auto companies have almost as many retirees as active workers. This factor gives the Japanese transplant facilities a considerable cost advantage over the domestic companies. A

study by the University of Michigan Transportation Research Institute estimated that the Japanese transplant facilities have a \$600 per car cost advantage over the Big Three automakers attributable solely to differences in health care costs, the biggest portion of which is due to differences in retiree health care costs.

The accounting standards which were recently promulgated by FASB for post-retirement medical benefits have aggravated the competitive problems posed by retiree health insurance coverage. This accounting standard requires companies to recognize retiree health liabilities for current and future retirees on their financial statements. General Motors announced a one-time FASB charge of 20.8 billion in 1992; Ford reported a one-time charge of \$7.5 billion; and Chrysler reported a one-time charge of 4.7 billion. Equally alarming, the Big Three automakers will each have to report substantially increased charges for retiree health care benefits each year, over and above the cash outlay for these benefits that was previously reported. For GM, this additional charge is about \$1.4 billion. By comparison, even in its best years GM only made a profit of about \$3 billion. Thus, the FASB retiree health standard will have a major negative impact on the Big Three automakers. This was demonstrated when GM's securities were downgraded shortly after it announced its FASB charge for 1992.

It is important to recognize, however, that the Big Three automakers are not the only ones who have been struggling with retiree health care liabilities. Similar dynamics are at work in other major industries, including agricultural implements, steel, mining, telecommunications, and airlines. In addition, many state and local governments have been encountering growing problems sustaining health care liabilities for retirees. And many Taft Hartley health and welfare funds also face this same problem.

The Clinton health plan would address the problems associated with providing health care to early retirees in several ways. Most importantly, it would guarantee health insurance coverage for early retirees, just like the rest of Americans. Thus, early retirees who currently have coverage would no longer have to fear cutbacks or the outright termination of their health care benefits. And retirees who currently do not have coverage would be provided the same package of federally guaranteed benefits. Thus, all early retirees would stand to gain from the Clinton plan.

At the same time, the Clinton plan would provide for equitable financing of this coverage for early retirees, by spreading these costs uniformly throughout society. Older companies that happen to have larger numbers of early retirees would no longer be placed at a competitive disadvantage. Newer companies with no retirees would no longer be given a "free ride". Under the existing Medicare program, the costs of providing coverage to post-65 retirees are spread uniformly throughout society. The Clinton plan would simply expand this eminently fair approach to pre-65 retirees.

The early retiree provisions in the Clinton health care plan do not represent a "bail out" or undeserved "windfall" for those companies which have provided retiree health insurance coverage in the past. Rather, these provisions simply represent another example of the Administration's commitment to the principle that there should be a "level playing field" between all employers, so that companies are not forced to compete on the basis of health care costs.

In our view, it is just as inappropriate to compel companies to compete on the basis of retiree health care costs, as it is to require them to compete on the basis of health care costs for active workers. If all employers should be required to contribute to the cost of providing coverage for active workers,

and should be required to share equally the costs of providing coverage for sick or older workers, then it also makes sense to require all employers to share equally the costs of providing coverage for retired workers and their families.

Unless this principle is adopted with respect to retiree health insurance coverage, as well as coverage for the active workforce, there will continue to be significant retrenchment and job loss in certain key manufacturing industries. Many of the companies with large retiree health liabilities are facing declining market share, resulting in lower production and employment. This in turn can create a vicious cycle. As these companies downsize, the ratio of retirees to active workers increases. The FASB problem and competitive disadvantage become worse. There is a further decline in market share, followed by more cutbacks in production and additional job loss. In the end, companies may have to file for bankruptcy, or may even be forced entirely out of business.

The recent problems at Navistar provide a clear example of this potential danger. Navistar has three retirees for every active worker. Last year it became apparent that the survival of the company and the jobs of the 7,500 active UAW employees (and 11,000 total employees) were threatened by the size of the company's retiree health liability. After painstaking, difficult negotiations, the UAW was successful in reaching a solution with Navistar which allows the company to continue in business, while protecting a modified level of retiree health benefits. Make no mistake, however, these negotiations required serious changes and sacrifices for UAW Navistar active workers and for all Navistar retirees.

Thus, in addition to assuring the security of health care benefits for early retirees, the provisions in the Clinton health care plan also will play an important role in restoring the competitiveness of many important sectors of the American economy. This not only will preserve existing jobs; it also will provide the basis for renewed economic growth that can generate new jobs in the future.

5. Limits on Family Costs

The Clinton health plan would place limits on the premiums and cost sharing which families are required to pay for health care. Specifically, families would be guaranteed that their premiums for the federally guaranteed package of benefits cannot exceed 3.9 percent of wages. In addition, the premiums would be subsidized for workers below 150 percent of the poverty line, and for unemployed individuals below 250 percent of the poverty line.

Furthermore, regardless of what type of plan a family enrolls in (i.e. an HMO, PPO, or fee-for-service plan), out-of-pocket costs for deductibles and copayments will be capped at \$1500 for an individual and \$3000 for a family. Cost sharing requirements under HMOs and PPOs will be kept very low (generally \$10 per visit for outpatient services). And there will not be any cost sharing requirements for preventative health care services.

To stop health care providers from circumventing cost containment mechanisms, the Clinton plan also would prohibit balance billing by providers. This will protect families against additional, hidden charges.

The UAW strongly supports all of these features in the Clinton plan. Together they will help to provide genuine health security for American families. Persons will no longer have to live in fear that they could lose their life's savings and their home as a result of catastrophic medical expenses. And they

will no longer be deterred from seeking needed medical services because of excessive out-of-pocket costs.

The UAW urges the Administration and Congress to consider lowering the cap on family premiums from 3.9 to 2 percent of wages. We believe this would provide more complete protection for low and moderate income families.

The UAW is troubled by the recent addition of an overall ceiling on the cost of the subsidies for families. We urge Congress to eliminate this ceiling, in order to guarantee that sufficient assistance will be made available to limit premiums and cost sharing requirements for families.

6. Tax Cap

The Clinton health plan would preserve the existing preferential tax treatment for all health care benefits that would be covered under the federally guaranteed package. Workers would not be required to pay taxes on these benefits, and employers could continue to deduct the cost of their premium payments for these benefits.

In addition, the Clinton plan would continue this same preferential tax treatment for any employer payments for the family share of premiums for the federal package of benefits, and for any cost sharing requirements (i.e. copayments and deductibles) under that federal package.

In situations where employers are currently providing benefits beyond the federal standard, the Clinton plan would "grandfather" the tax free status of these benefits for a period of ten years. After that time, workers would have to pay tax on the value of these benefits (but employers could continue to deduct the cost of these benefits as a business expense). However, since the federal benefit package under the Clinton plan is comprehensive, very few benefits would eventually be subject to taxation.

The UAW believes as a matter of principle that workers should not be required to pay taxes on their health care benefits. We commend the Administration for preserving the tax free status of most benefits. In rejecting suggestions that they should support a tougher "tax cap" on health care benefits, the First Lady has forcefully expressed the view that it would be wrong to subject 35 million Americans to a substantial tax increase. The UAW wholeheartedly concurs with this assessment.

The taxation of health care benefits would result in a large tax on the middle class. It also would lead to a reduction in important health insurance coverage. And it would not be an effective mechanism for slowing the growth in health care costs. For these reasons, the UAW continues to oppose the various proposals which have been advanced to alter the current tax treatment of health care benefits.

7. Senior Citizens

The Clinton health plan contains two provisions of particular importance to post-65 senior citizens. First, it would expand Medicare to cover outpatient prescription drugs (similar to the benefits which would be provided to the under 65 population). Second, it would establish a new long term care program to provide home and community based care for disabled individuals.

The UAW strongly supports both of these initiatives. We have long supported the expansion of Medicare to cover prescription drugs. Senior citizens currently are forced to spend an ever increasing portion of their income to obtain this essential coverage. Often they must make difficult decisions between spending money for prescription drugs that will keep them

healthy or using their scarce resources to buy food, clothing and other necessities. By expanding Medicare to cover prescription drugs, we can put an end to this terrible situation and assure that all senior citizens have access to this important protection.

It is also worth noting that this provision will help to reduce the retiree health insurance liabilities of many major employers, especially older manufacturing companies that typically provide this coverage to their post-65 retirees. This in turn will help alleviate the FASB and competitive problems facing many of these companies, and thereby help to generate greater economic growth.

The UAW also has long been on record calling for a comprehensive long term care program. We view the Clinton proposal as an important first step in that direction. It addresses the most pressing need for expanded home and community based services that will allow disabled individuals to remain at home as long as possible. These services help to preserve the dignity of disabled individuals. And they have been proven to be more cost effective than custodial care.

8. Regional Alliances

The Clinton health plan would require the states to establish one or more regional alliances which would act as "purchasing cooperatives" for health insurance coverage. Most families would receive their coverage through these regional alliances.

The UAW believes this aspect of the Clinton health plan represents a positive step towards the ultimate goal of a single, unified health care system. Requiring most individuals to receive their coverage through regional alliances will produce several important benefits. It will give the alliances sufficient bargaining power to be able to negotiate better rates with health care providers, and to thereby hold down health care costs. It will help to reduce administrative waste. And it will help to preserve the principle of community rating, so that all employers and families share equally in the costs of providing coverage to sick and older persons.

The UAW opposes the provision in the Clinton health plan that would allow employers with more than 5000 workers to opt out of the regional alliances. And we are strongly opposed to the proposals which have been advanced by some persons to lower the threshold for employer opt outs to 500 or 100 workers. This would weaken the bargaining power of the alliances. It would increase administrative complexity and waste. And it would undermine the principle of community rating.

Employers with lower cost workforces (because they are healthier or younger) will decide to opt out, so they can get the benefit of their lower experience rates. The alliances will then be left with older, sicker workers. As costs begin to spiral upwards, there inevitably will be pressures to cut back on benefits. In the end, we will be left with a two tier health care system. Employers and their workers who have opted out of the alliances will receive comprehensive benefits and excellent quality of care. Those companies and workers who are left behind in the alliances will be forced to accept substandard benefits and inferior quality of care.

To prevent the alliances from becoming the dumping ground for bad risks and the resulting establishment of a two tier system of health care, the alliances must be made as broad as possible. The UAW believes that no employers should be allowed to opt out. Instead, there should be a single system which encompasses everyone. At a minimum, however, there must not be any retreat from the 5000 threshold contained in the Clinton health plan.

9. Single Payer Option

The Clinton plan would allow the states to establish single payer systems. This means there could be just a single alliance or other payer within the state. In addition, it means that the states could decide to have the single payer directly establish the reimbursement rates for health care providers (through global budgets for hospitals and fee schedules for physicians and other providers).

The UAW has long supported the single payer approach to national health care reform. For this reason, we have endorsed the single payer proposal set forth in the Wellstone-McDermott bill (S. 491; H.R. 1300). We continue to believe that this approach represents the best means of guaranteeing universal coverage, containing escalating costs, and assuring high quality of care.

The UAW supports the Clinton health plan because, in our judgment, it is consistent with many of the important principles embodied in the single payer approach to national health care reform. It would guarantee comprehensive health insurance coverage to all Americans regardless of health or employment status. It would contain escalating health costs through enforceable budgets. It would establish a level playing field between employers and address the problems associated with retiree health care benefits. It would place limits on the premiums and cost sharing which families are required to pay for health care services. And it would preserve the preferential tax treatment for health care benefits.

In addition, by expressly allowing the states to establish single payer systems, we believe the Clinton plan would provide the basis for gradually moving to a national single payer system. Thus, the UAW believes it is critically important that the state single payer option be retained in the Clinton health plan.

10. Quality of Care

The Clinton health plan contains a number of features designed to guarantee high quality of care. First, and perhaps most importantly, the Administration's proposal would significantly expand the choice of physicians and other health care providers for many Americans. At the present time, individuals are generally limited to the health care plans offered by their employers. In recent years, employers have increasingly limited the choice of plans available to workers in an effort to contain rising costs. Thus, many workers have found their choice of providers severely restricted.

The Clinton plan would expand the choice of providers by allowing families to enroll in any of the health care plans offered under their regional alliance. And in those situations where large employers have opted out of the regional alliances, these companies would still be required to give their workers a choice of at least three health care plans, including a fee-for-service plan. Thus, no employer would be able to insist that all of its workers and their families must be enrolled in an HMO or PPO. The choice will be left where it rightfully belongs, with the workers and their families.

The UAW is also pleased that the Clinton plan includes provisions to increase spending on public health programs that will ensure adequate access for underserved areas and populations. This is essential for both rural areas and our inner cities.

The UAW fully supports the provisions in the Clinton plan that would require health alliances to disseminate information to consumers on the quality of health plans. And we welcome the

provisions requiring practice guidelines and performance feedback for health care providers.

The UAW also supports the provisions in the Clinton health plan that would:

- * establish an ombudsman to assist consumers;
- * assure the privacy of health records;
- * establish limits on attorneys fees in malpractice cases; and
- * increase the numbers of family and general practitioners, and reduce the numbers of medical specialists.

We believe these measures would all contribute to the delivery of high quality health care.

Competing Proposals

A number of proposals have already been advanced in Congress as alternatives to the Clinton health plan. In addition to the Wellstone-McDermott bill, there are two other major alternatives: the Chafee proposal and the Cooper-Breaux bill. The UAW strongly opposes the Chafee proposal and the Cooper-Breaux bill. In our judgment, these proposals would not solve the serious problems confronting our health care system. Instead, they are thinly disguised attempts to maintain the status quo.

The Chafee and Cooper-Breaux proposals would not guarantee universal coverage in the near future. The Chafee proposal asserts that all individuals would eventually be required to have health insurance coverage, but admits that this is a distant goal that would only gradually be achieved at some distant date. The Cooper-Breaux bill never even purports to guarantee universal coverage. It allows all individuals to buy health insurance through purchasing cooperatives, but does not provide any financing mechanisms to make coverage affordable for all Americans. As a result, CBO estimated that this approach would leave 25 million Americans without health insurance coverage.

The UAW believes this is unacceptable. To be meaningful, health care reform must achieve the goal of universal coverage in the near future. The Chafee and Cooper-Breaux proposals fail to meet this challenge because they do not step up to the hard decisions on how to finance universal coverage. They both reject the notion of an employer mandate. But this inevitably leads to two choices: either taxes must be raised to provide coverage to the uninsured, or else the goal of universal coverage must be abandoned. Regrettably, the Chafee and Cooper-Breaux proposals opt for the second alternative.

It is worth noting that the adamant opposition to an employer mandate which forms the basis for the Chafee and Cooper-Breaux proposals is inconsistent with the theory of "managed competition" which they purport to embrace. The father of "managed competition", Alain Enthoven, and the Jackson Hole Group have long supported the concept of an employer mandate. They have recognized that this is necessary to prevent employers from "dumping" their workers onto public programs which subsidize health care for the uninsured. The fact is, without an employer mandate "managed competition" cannot work. Either government costs for subsidies will sky rocket or else large numbers of persons will remain uninsured.

The Chafee and Cooper-Breaux proposals also fail to take serious steps to contain escalating health care costs. In particular, they do not include any provisions for enforceable budgets to restrain the growth in health care expenditures. Despite all of their rhetoric about fostering competition between

health plans, achieving administrative savings, and reforming our malpractice laws, the fact is the Chafee and Cooper-Breaux proposals avoid the tough measures which are necessary to bring costs under control. Without an overall budgeting mechanism, there is no guarantee that health care costs will be controlled. In effect, the health care industry will continue to have a blank check from the government and the American people.

It is likely that the Chafee and Cooper-Breaux proposals would actually aggravate the escalation of health care costs. Because they would both provide subsidies to help cover low income individuals, they would both increase overall expenditures on health care. But since they do not combine this with any overall budgetary restraints, there is nothing to prevent costs from skyrocketing. In effect, the Chafee and Cooper-Breaux proposals adopt the approach of simply "throwing money" at the problem of the uninsured, without adopting any overall constraints that will force health care plans and providers to operate more efficiently.

The Chafee and Cooper-Breaux proposals would also make major changes in the tax treatment of health care benefits. The Chafee proposal would require workers to pay taxes on their health care benefits to the extent the cost of their plan exceeds the average cost of the three cheapest plans in their region. The Cooper-Breaux bill would deny a deduction to employers for the cost of any health care plan to the extent it exceeds the price of the cheapest plan in the region. These two approaches are really just two different sides of the same coin. Both would penalize workers and employers that have comprehensive health care plans, with low cost sharing requirements. This would place tremendous pressure on workers and employers to cut back on health care coverage. This in turn would shift enormous costs to families. But it would not do anything to contain escalating costs.

It is important to note that the Chafee proposal would impose a sizeable tax increase on middle class families. Approximately 35 million Americans would be hit by this new tax. The additional tax liability could mount to hundreds of dollars for a typical family. During the recent debate over the budget reconciliation legislation, many Senators spoke at length about the evils of tax increases that were primarily directed at wealthy individuals. It is indeed ironic that some of these same Senators are now supporting the Chafee health care proposal, whose central component is a substantial tax increase on the middle class.

Finally, the Chafee and Cooper-Breaux proposals would not require most employers to join regional purchasing alliances. This is justified on the basis that they do not want to create new bureaucracies and or a so-called "one-size fits all" mentality. When one looks behind this lofty rhetoric, however, it becomes apparent that the approach embodied in the Chafee and Cooper-Breaux proposals would have two major impacts. First, it would preserve the existing multitude of private insurance carriers. This in turn would continue the exorbitant levels of administrative waste associated with the current system. One study has shown that private insurance carriers spend 36.4 cents on administration, marketing and overhead for every dollar they spend on claims, compared to only 2.1 cents for Medicare. Thus, the Chafee and Cooper-Breaux proposals actually preserve wasteful bureaucracy, not prevent it.

Second, the approach adopted by the Chafee and Cooper-Breaux proposals would quickly undermine the principle of community rating. Employers with younger, healthier workers would decide to opt out and provide coverage on their own. The purchasing alliances would soon become the dumping grounds for sicker, older workers. As the costs in the alliances spiral upwards due to adverse selection, there will inevitably be demands to cut back on benefits. The end result will be a two tier health care

system. Employers and workers outside of the alliances will be able to receive comprehensive, quality health care services, whereas those that remain in the alliances will be forced to accept reduced benefits and substandard quality of care.

Conclusion

In conclusion, Mr. Chairman, the UAW appreciates the opportunity to testify before this Committee on the subject of President Clinton's health care reform proposal. The UAW strongly supports the President's proposal. We believe it embodies a number of principles which are necessary to provide genuine health care reform.

The UAW recognizes that Congress is now embarking on a long process of considering health care reform legislation. We look forward to working with you, Mr. Chairman, and with the other Members of this Subcommittee, as you take on this difficult but rewarding challenge. Thank you.

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Chairman STARK. Thank you very much.
Mr. Ray.

STATEMENT OF ROBERT A. GEORGINE, PRESIDENT, BUILDING AND CONSTRUCTION TRADES DEPARTMENT, AFL-CIO, AS PRESENTED BY JAMES RAY

Mr. RAY. Thank you, Mr. Chairman.

I have the pleasure of appearing here on behalf of Robert A. Georgine, President of the Building and Construction Trades Department of the AFL-CIO. Bob had hoped and wanted very much to be with you today. Unfortunately, he was unavoidably detained out of town. He sends his apologies and his thanks for giving us the opportunity to appear before you and testify on the important subject of health care reform, and in particular, President Clinton's proposal.

Mr. Chairman and members of the subcommittee, among the proudest achievements of our unions is the system of Taft-Hartley multiemployer health and welfare plans that provide our members and their families with medical, health, hospital, sickness, death, disability, and related benefits. But for these multiemployer plans, few of our members would have health and welfare benefits coverage because of the mobile and seasonal employment patterns in the building and construction industry and the small size of most construction industry employers.

For several decades now where multiemployer health and welfare plans have been accommodating these employment patterns by providing a central fund through which portable coverage is provided to members as they move from one participating employer to another, in effect, all of the participating employers, scores, hundreds, or even thousands of employers, are treated as a single employer for purposes of providing health and welfare benefits coverage for members and their families.

Our health and welfare plans are financed, in reality, by our members through their labor. Our collective bargaining agreements typically require signatory employers to contribute to a particular health and welfare plan at a set dollars and cents rate for each hour worked by a covered employee. While the law considers these to be employer contributions, the reality is that the employers' contributions are substitute wages for labor received.

The nature of collective bargaining in our industry is that total compensation package cost is negotiated with the employers and the workers, through their union, decide how to allocate the total hourly rate among cash wages, pensions, health and welfare, apprenticeship and training, and other beneficial programs. This process makes our members very sensitive to the increases in the cost of health care coverage.

Over the years, the labor management boards of trustees of our plans, with professional assistance, have designed health and welfare programs that balance the benefit needs and wants of covered workers with the available financing that can be provided by collectively bargained contributions. By pooling the contributions of many employers into a central fund, multiemployer health and welfare plans enjoy economies of scale and administration, as well as enhanced purchasing power in dealing with health care providers

and insurers. In effect, multiemployer plans have been the prototype health alliance for decades.

With respect to the current system, our unions have been proud to have taken care of our members over the years and to have dealt with the problems that have arisen ourselves. But the current crisis in the health care and insurance system confronting our health and welfare plans and our members is beyond our control. These forces are endangering the very survival of our multiemployer plans and the financial security of our members and their families. Only action by the Federal Government to comprehensively reform the current system can bring these forces under control.

Skyrocketing inflation, the cost of health care and insurance has cut severely into our wages. Many health and welfare plans' trustees have been compelled by cost pressures to cut back benefits, tighten eligibility rules, and increase out-of-pocket payments to their workers.

While we have struggled with these pressures to maintain responsible health care coverage for our members, our nonunion competition has gained an unfair competitive advantage. The typical nonunion contractor does not provide health insurance for its employees. If it provides any, it is inadequate coverage. This social irresponsibility gives the nonunion contractor an immediate cost advantage over responsible union contractors, which contribute to our plans.

This unfair competitive advantage is multiplied when the uninsured nonunion worker or his family needs medical treatment. Lacking insurance coverage, they have no regular doctor but rather go to a hospital emergency room for treatment of minor and major ailments and pass the costs on to our plans and our members.

Mr. Chairman, if I may just say a few words about the President's proposal, we are supportive of President Clinton's proposal. We believe it goes a long way toward solving the problems that our plans, our members, and our employers are confronting. The following aspects of the proposal are of particular importance to us.

One, that the proposal would require all employers to pay their fair share for the cost of providing health care to their employees; that the proposal puts in place mechanisms for controlling health care cost inflation; that the proposal would allow our multiemployer plans to form their own labor-management health alliances; and the proposal would permit multiemployer plans to continue to pay the full premium costs for benefit coverage and to offer supplemental plans.

These, of course, Mr. Chairman, are broad strokes and the devil is in the details. We need to make sure that the advantages that the President's proposal offers to our members are not placed out of reach by operational impediments.

We have not yet had a full opportunity to review and analyze the revised version of the proposal. However, we understand that the details will be subject to discussion and further revision, as affected groups are able to become familiar with it, and we look forward to having that opportunity.

Thank you very much.

[The prepared statement and attachment follow:]

**STATEMENT OF ROBERT A. GEORGINE, PRESIDENT,
BUILDING & CONSTRUCTION TRADES DEPARTMENT, AFL-CIO**

Mr. Chairman and Members of the Subcommittee:

My name is Robert A. Georgine. I have the honor of serving as President of the Building and Construction Trades Department of the AFL-CIO. I am pleased to appear before you today on behalf of the 15 national and international unions affiliated with the Department and the more than six million workers they represent to discuss health care system reform and, in particular, President Clinton's reform proposal.

The Nature of Multiemployer Health & Welfare Plans

Among the proudest achievements of our Unions is the system of multiemployer health and welfare plans that provide our members and their families with medical, hospital, sickness, death, disability, and related benefits.^{1/} But for these multiemployer plans, few of our members would have health and welfare benefits coverage because of the mobile and seasonal employment patterns in the building and construction industry, and the small size of most construction industry employers.

A building tradesman may be employed by a particular employer for only a day, a week, a month or a few months to work on a specific project, and then move on to work on another employer's project, and thereafter another, etc. Between jobs, he or she might be off work for a day, a week, a month, or longer. A building tradesman might work for scores of different employers over his or her working life, with periods of unemployment between jobs. Most construction employers would not maintain their own employee health plans, particularly for transient workers.

^{1/} *A multiemployer health and welfare plan, often referred to as a "Taft-Hartley plan," is:*

- *a trust fund established through labor-management collective bargaining and pursuant to the Labor Management Relations ("Taft-Hartley") Act of 1947 by one or more labor unions and more than one employer of the union-represented workers;*
- *administered by a joint board of trustees with equal labor and management representation;*
- *providing medical, hospitalization, and other health-related benefits, as well as death, disability - and sickness benefits; to covered workers and their dependents; and*
- *financed by employer contributions which are collectively-bargained between the sponsoring union(s) and the participating employers.*

These structural requirements are imposed by Section 302(c)(5) of the Taft-Hartley Act [29 U.S.C. §186(c)(5)]. Multiemployer health and welfare plans are also regulated by the Employee Retirement Income Security Act (ERISA) as employer welfare benefit plans.

For several decades now, our multiemployer health and welfare plans have been accommodating these employment patterns by providing a central fund through which portable coverage is provided to members as they move from one participating employer to another. In effect, all of the participating employers -- scores, hundreds, and even thousands of employers -- are treated as a single employer for purposes of providing health and welfare benefits coverage to members and their families.

Our multiemployer health and welfare plans are financed, in reality, by our members through their labor. Our collective bargaining agreements typically require signatory employers to contribute to a particular health and welfare plan at a set dollars-and-cents rate for each hour worked by a covered worker. While the law considers these to be "employer contributions," the reality is that the employer's contributions are substitute wages for labor received. Instead of putting this money into the worker's paycheck, the employer pays it to the health and welfare plan to finance benefits coverage for the worker and his family.

The nature of collective bargaining in our industry is that the total compensation package cost is negotiated with the employers and the workers, through their Union, decide how to allocate the total hourly rate among cash wages, pensions, health and welfare, apprenticeship and training, and other beneficial programs. An increase in the contribution rate for the health and welfare plan means less in wages, or less in pension plan contributions, or less in contributions to another benefit plan. This process makes our members very sensitive to increases in the cost of health care coverage.

From the plan's perspective, financing depends upon the level of covered work, as well as the collectively-bargained contribution rate. That is, the plan generally receives employer contributions only for hours worked in employment covered by a collective bargaining agreement. If the level of covered work declines, plan income declines. The per hour contribution rate set by the collective bargaining agreements

usually cannot be increased unless and until the labor-management parties negotiate a new or modified agreement. A multiemployer plan cannot simply reach into the corporate treasury of an employer, in contrast to single-employer corporate plans.

Over the years, the labor-management boards of trustees of our plans, with professional assistance, have designed health and welfare programs that balance the benefit needs and wants of the covered workers with the financing that can be provided by the collectively-bargained contributions. To balance these factors, the trustees have developed various eligibility rules, benefit packages, and operational practices tailored to their particular circumstances. For example, plans have developed various systems for continuing coverage during gaps in employment and into retirement. These systems include "hours-bank" arrangements under which a worker's hours of covered employment are "banked" and used to pay for benefit eligibility during periods of unemployment. Other systems use eligibility periods during which a worker's covered employment builds credit towards benefit eligibility in a future period (e.g., covered employment in the first quarter earns the worker benefit eligibility for claims incurred in the second quarter).

By pooling the contributions of many employers into a central fund, multiemployer health and welfare plans enjoy economies of scale in administration as well as enhanced purchasing power in dealing with health care providers and insurers. Multiemployer plans are prototype health alliances. Many of our plans are self-funded. Many others insure some or all of their benefits with commercial carriers or other health insurers. Some of our plans have in-house administration, although most use professional third-party administrators who answer to the labor-management board of trustees.

Participating employers are advantaged in that they are required to do little other than submit their periodic contributions to the plan with verifying information. The employers need not become involved in plan administration or plan

design. These functions are the responsibility of the plan's labor-management board of trustees and the professionals they hire.

Many multiemployer health and welfare plans cover workers in multiple States. Some multiemployer plans are national in coverage. Fortunately, because of federal preemption under the Employee Retirement Income Security Act (ERISA), most of our multi-state plans are not subject to regulation by the States. The cost and operation of these plans, if not their very existence, would be adversely affected if the plans were subject to multiple, inconsistent regulation by the States in addition to Federal regulation. Every dollar spent by a plan on regulatory compliance and administration is a worker's dollar, and a dollar that cannot be returned to covered workers in the form of benefits.

Even intra-state multiemployer health and welfare plans would be adversely impacted if States, as well as the Federal government, could regulate them. This adverse impact is evidenced today by a loophole in ERISA preemption opened by the U.S. Supreme Court. This loophole allows States to mandate the benefit packages of insured employee health plans by requiring insurers to include certain benefits or services in all health insurance policies they issue, including policies sold to employee health plans. This loophole has driven many, if not most, multiemployer plans to become self-funded ("self-insured") and avoid State control over the benefits they provide and the costs they incur, inasmuch as such governmental control interferes with the trustees' ability to balance the plan's benefit costs with the available financing.

Problems With Current System

Our Unions are proud to have taken care of our own over the years, and to have dealt ourselves with problems that have arisen over the years.

But, the current crisis in the health care and insurance system is confronting our health and welfare plans, and our members, with forces beyond our

control. And, these forces are endangering the very survival of our multiemployer plans and the benefit security of our members and their families.

Only action by the Federal government to comprehensively reform the current system can bring these forces under control.

Skyrocketing inflation in the cost of health care and insurance has cut severely into wages. We have had to shift increasing amounts of wages into health and welfare contributions to offset cost increases. In many cases, cash wages have been frozen, with negotiated increases being redirected into the health and welfare plans to keep them afloat. In some areas, pension plan contribution rates have been reduced by the bargaining parties, with the savings being rechanneled to the health and welfare plans.

Many health and welfare plan boards of trustees have been compelled by cost pressures to cutback benefits, tighten eligibility rules, and increase out-of-pocket payments by covered workers. Our members no longer feel so secure about their coverage, particularly if they are unemployed for extended periods, as many have been during this long-running economic recession.

The effects of inflation in the cost of providing benefits have been exacerbated by the declines in contribution income to our plans caused by the recession. Fewer jobs to generate contributions means less income to our plans, even as benefit claims increase. Retirements induced by the unavailability of steady employment in some areas have increased the burden for those plans that provide coverage for retirees.

The recession in the building and construction industry itself is a product, in part, of health care cost inflation. As health care costs consume ever-increasing portions of government budgets and private sector resources, less money is available for investment in public and private building and construction projects. This means fewer jobs for our members, and less income for our health and welfare plans.

While we have struggled with these pressures to maintain responsible health coverage for our members, our non-union competition has gained an unfair competitive advantage. Non-union contractors have found a way to shift the cost of medical treatment for their employees and families onto the backs of our health and welfare plans and members; a way to cut their costs and increase ours.

The typical non-union contractor does not provide health insurance for its employees. If it provides any, it is inadequate coverage. This social irresponsibility gives the non-union contractor an immediate cost advantage over responsible union contractors which contribute to our multiemployer health and welfare plans.

This unfair competitive advantage is multiplied when the uninsured non-union worker or his family needs medical treatment. Lacking insurance coverage, they have no regular doctor, but rather go to hospital emergency rooms for treatment of minor and major ailments; the most expensive place to get treatment. And, when the worker is unable to pay for the treatment, the cost is passed onto our multiemployer health and welfare plans in the form of higher hospital bills, higher insurance premiums, and State uncompensated care assessments.

In other words, our members are being compelled by the current system to pay twice for health care: once for themselves and their families, and a second time for the non-union workers who take our jobs and their families.

In short, our members are generally pleased with their health and welfare plans; plans which have been custom designed for them and which they control through collective bargaining and through the plans' boards of labor-management trustees. But, health care cost inflation and cost-shifting beyond our control is undermining the plans and our members' standard of living, while placing them at an unfair competitive disadvantage.

These mixed emotions about the current system translate into a strong feeling that comprehensive, national reform is needed immediately to deal with cost

inflation and cost-shifting, as well as with concerns about the quality of care, but that the reforms should enable us to retain what is good about our multiemployer health and welfare system so that our members will not be worse off under a restructured system.

President Clinton's Proposal

We support President Clinton's reform proposal. We believe that it goes a long way towards solving the problems confronting our members, our plans, and our employers, while preserving maximum flexibility for multiemployer health and welfare plans to continue to play a major role in the restructured health system for the benefit of our members. The following aspects of the proposal are particularly important to us.

- * The proposal would require all employers to pay their fair share of the cost of health care for their employees. Non-union contractors would no longer have a free-ride at the expense of our members and responsible employers.
- * The proposal would put in place mechanisms for controlling health care cost inflation.
- * The proposal would enable multiemployer health and welfare plans to form their own labor-management health alliances, either individually (if a plan meets the size criteria) or collectively, reflecting the fact that our plans have been operating as de facto health alliances for decades. In addition, the proposal would give a multiemployer plan the option of joining a government-sponsored Regional Health Alliance on behalf of its participating employers; that as an intermediary between the employers participating in the plan and the Regional Health Alliance. The basic health benefit package could be obtained through the Regional Health Alliance,

with the multiemployer health and welfare plan providing supplemental health benefits and non-health benefits (e.g., disability, death, sick pay benefits) as they do now.

- The proposal would permit multiemployer health and welfare plans to continue to pay the full "premium" cost for benefit coverage, and would not require plans to impose deductibles, co-payments, or benefit limits. And, neither our members nor our participating employers would suffer adverse tax consequences as a result. This reflects the fact that our members already pay the full cost of benefit coverage by accepting a portion of their compensation package in the form of employer contributions to their health and welfare plans; a characteristic that makes our members well aware of the cost of health care benefits to them.
- The proposal would permit multiemployer health and welfare plans to continue to provide supplemental health benefits not included in the basic benefit package without adverse tax consequences to our members or our participating employers for at least ten years.
- The proposal would extend government-financed health coverage to our retirees, and ease the financial pressure on active workers who currently subsidize the health coverage for retired members.
- The proposal would make a start towards reforming the fractured workers compensation system.

- The proposal would compel improvements in the quality of medical care by, among other ways, refocusing the system from treatment to preventive care and requiring greater accountability by providers of care.

These, of course, are broad strokes. And, the devil is in the details. We need to make sure that these advantages of the President's proposal are not placed out of reach by operational impediments.

We have not yet had an opportunity to review and analyze the revised version of the President's proposal that was unveiled yesterday. However, we understand that the details will be subject to discussion and further revision as affected groups are able to become familiar with the new proposal.

Several of our important technical concerns are explained in the attached paper which I offer as part of my submission to you. I ask you to include these concerns in your consideration of the proposal.

Thank you.

Attachment to Testimony of
Robert A. Georgine to the
Ways & Means Subcommittee
on Health
October 28, 1993

A. Supplemental Benefits

Supplemental benefits are of profound importance to Taft-Hartley funds. Among other things, they will typically be necessary to protect participants from losing benefits when the uniform national benefit package is introduced. For example, almost all Taft-Hartley funds provide fully-paid coverage for active employees and their families; supplemental coverage would be needed to preserve that, since the minimum benefit package will require employee contributions. It is essential that the health care reform structure promote – or at least, avoid impeding – the efficient and flexible provision of supplemental benefits.

Here are some suggestions to help accomplish that, which apply both for employees who receive basic health coverage through a Regional Alliance and those covered through an independent Health Alliance sponsored by their Taft-Hartley fund.

a. Employer-funded supplemental benefits (including those for which an employee contribution may be required) must not be subject to National Health Board controls on the benefit design, funding and reserve requirements, standard policy terms, etc. Since Taft-Hartley funds do not "market" employer-funded supplemental benefits to their participants the way commercial insurers might, there is no need to regulate Taft-Hartley funds in this connection to prevent marketing abuses.

b. In a Taft-Hartley plan the precise level of employer contributions that will be received from year to year is unpredictable, as contributions – typically based on hours worked by plan participants – rise and fall with the availability of covered work. Plans should be able to enrich or roll back supplemental benefits in response to the ebb and flow of plan income, as long as the participants are given reasonable notice of any changes and a benefit reduction does not apply retroactively to expenses incurred before notice of the change was given.

c. Taft-Hartley groups should be able to provide employer-funded supplemental benefits through employee welfare benefit plans that may but need not be part of a regional or independent health alliance. However, for employees covered through a Regional Alliance who are entitled to supplemental coverage, the Regional Alliance should arrange to have the health plans with which they contract provide employer-paid supplemental benefits along with basic coverage, if a plan sponsor wants to handle it that way.

d. There should be no restrictions on an employee benefit plan sponsor's flexibility to provide different types or levels of supplemental benefits to different employees.

e. It should be clear that if, as of a specified date, an employee welfare benefit plan offers benefits that are treated as supplemental under the health care reform proposal, the favorable tax treatment of those benefits is grandfathered for all people who remain or become covered under that plan during the grandfather period. To qualify for this grandfather treatment,

benefits should be provided under a plan as of a date that is no earlier than the date of enactment of national health care reform.

f. If, because of cost concerns, the guaranteed benefit package is cut back to exclude an item of basic coverage such as, for example, prescription drug benefits, Taft-Hartley funds should be able to provide those benefits without triggering taxes on the covered employees. To the extent a supplemental benefit is taxable, it should be clear that plan participants are taxed on the premium or coverage value and not on the amounts actually paid for their care.

g. The eligibility of employers and employees for government subsidies to defray the cost of coverage should not be affected by their providing or receiving supplemental benefits or coverage, even though the subsidies would be payable only with respect to the legally required benefit package.

B. Multiemployer Plans Outside a Regional Alliance

Taft-Hartley multiemployer plans have almost 50 years of experience delivering portable, cost-effective health coverage to employees of large groups of employers, and their families. The plans came into being as a way to assure that union-represented workers, particularly those who move frequently from job to job, have the security of "health care that's always there." The plans are designed and run by people who share and understand the health coverage needs of their participants, and they are specially adapted to meet those needs. The overriding challenge for Taft-Hartley funds today is finding the means to continue offering quality coverage and service, in the face of rampaging health care cost inflation. What the unions and employers who sponsor these plans, and the families that they cover, most want to achieve through national health care reform is control over those costs so that our country can afford to promise decent health care for everyone.

Understanding the Administration's judgment that some redesign of the institutions that provide health coverage and services is necessary to control costs, the multiemployer community applauds the Administration's commitment to preserving and fostering independent Taft-Hartley coverage arrangements as part of the restructured health care system. To make this option meaningful, a number of technical features should be clarified.

1. Independent health alliances for Taft-Hartley and other collectively bargained groups should be called "Labor-Management Alliances". They are not "corporate" alliances since they are the product of collective bargaining and, although the contributions are paid to the trust by corporations and other employers, the funds come from money that the employees, through their union, agree to divert from wages. In addition, the charter for some of these plans is based on labor laws other than the Taft-Hartley Act, such as the Railway Labor Act, state labor-relations

laws, or, in the case of certain pre-existing plans that are exempted from the Taft-Hartley rules, the National Labor Relations Act itself.

2. A Labor-Management Alliance should qualify as such if it covers at least 5,000 active eligible employees during a plan year, or on a single representative "snapshot date" during a plan year that is chosen by the Alliance's leadership. The 5000-person test should not be measured on a rigid or arbitrary basis. (Of course, if the threshold number is dropped for Corporate Alliances, that lower number would also apply to Labor-Management Alliances.)

3. Taft-Hartley and other collectively bargained funds should be able create a network to operate a Labor-Management Alliance, based, at a minimum, on the following types of affiliations:

- coverage of employees represented by units of the same international union,
- coverage of people living or working in the same geographic area (perhaps as defined by the Labor Department in the ERISA regulations on suspension of benefits, 29 CFR § 2530.203-3(c)(2)(iii)),
- coverage of employees working for the same employer or employers in the same industry, such as the Safeway employees, nationally or regionally, represented by the UFCW and the Teamsters, or supermarket employees in a designated area who are represented by either union. (However, care should be taken not to put too much weight on the concept of an "industry" as the unifying theme, to avoid creating definitional problems.)

4. A new collectively bargained health plan could join an existing Labor-Management Alliance network for which it qualifies. Also, it should be made clear that Labor-Management Alliances can be reconfigured after the initial phase, for example, by merging with other Labor-Management Alliances or with spun-off parts of them.

5. While substantially all of the employees covered through Labor-Management Alliances will be people working under collective bargaining agreements, as in today's Taft-Hartley funds they should also be able to cover certain others, such as:

- employees of related organizations, such as the fund itself, sponsoring union(s), other funds sponsored by the same union(s) (pension fund, vacation fund, apprenticeship fund, e.g.), third-party administrator, employer association;
- other employees of contributing employers, and
- others who "share an employment-related common bond" (as defined in the

rules for tax-exempt welfare benefit funds under §501(c)(9) of the Internal Revenue Code), if they make up no more than 10% of the covered group.

5. It should be made clear, under the new law and existing antitrust or any other relevant law, that any independent alliance may join with any other such alliances in purchasing groups (which would not themselves be health alliances), to coordinate their negotiations for and purchase of any or all covered or supplemental services.

6. While Labor-Management Alliances can set community-rated costs (premium equivalents) for all employers in any given region, coverage costs should be allowed to vary by region to take into account regional cost differentials.

7. Labor-Management Alliances should have the option to continue covering some or all of their part-time or unemployed participants or to transfer some or all of them to their local Regional Alliance. It would simplify Regional Alliance administration and avoid coverage disruption for employees and their families if, as is common in Taft-Hartley funds, individuals stay in the Labor-Management Alliance while temporarily between full-time jobs. Given the public benefit of this arrangement, those people and their employers covered should not be penalized by a loss of eligibility for public subsidies during those intervals.

Similarly, a Labor-Management Alliance that will be providing supplemental benefits for eligible early retirees or paying for part of their basic coverage should be able to provide their basic coverage as well, rather than being compelled to shift those early retirees into the Regional Alliance. A Labor-Management Alliance that takes on that responsibility should receive government funding for early retirees' coverage on the same basis as a Regional Alliance. And it should be made clear that an individual covered through a Labor-Management Alliance who becomes eligible for Medicare should, if authorized by the rules of the Labor-Management Alliance, have an option to stay in that Alliance on the same terms and with the same financial support that would be available for Medicare-eligible people who opt into a Regional Alliance.

8. To pay the costs of a Taft-Hartley fund, the union and employers agree, in collective bargaining, to spend part of the employees' pay package on health and other benefits, rather than wages. Economically and from the covered workers' practical perspective, the employees are the source of the funds that the employers contribute to the Taft-Hartley trust. In addition, Taft-Hartley funds maintain seamless coverage for people who have enough work in a given time period to be considered full time in the industry even though they may never work steadily enough for any one employer to be considered full time at that company. For many people covered by Taft-Hartley funds, the overall level of work for all contributing employers fluctuates sharply, so that a year of full-time service almost inevitably includes periods of part-time employment or unemployment. (Indeed, it is not unusual for Taft-Hartley funds to treat people as full time even if they never work as many as 30 hours a week, which is the test for "full time" under the September 7 draft of the Administration proposal.)

Workers generate the income for the Taft-Hartley funds that would make up Labor Management Alliances and Taft-Hartley funds typically offer them much the same kind of benefit security from that Regional Alliances would offer the rest of the population. Accordingly, employers contributing to Labor-Management Alliances should not also have to pay an assessment to fund the Regional Alliances, and they and their employees should be eligible for the same subsidies (other than the Regional Alliance's community rate) that they would have in a Regional Alliance.

9. If a Labor-Management Alliance disbands or individual groups bargain out of it and into a Regional Alliance, the premium caps that apply to those employers at that point should be based on each employer's size and pay levels, without regard to its having provided health coverage in association with a larger group.

10. Any new statutory remedies, causes of action or other mechanisms for enforcing employers' health benefit funding obligations should apply equally to employer contributions required to be made to a Labor-Management Alliance, but it should be made clear that these new enforcement procedures are available to the trustees of the funds that make up the Labor-Management Alliance in addition to the causes of action and remedies already available to them under state and federal law.

11. Certain features of the legally required benefit package as described in the September 7 draft document could make the management of health care difficult for all health plans, including those offered by Labor-Management Alliances, unless they are clarified. For example, the final proposal should make it clear that, if a health plan requires utilization review before covered services are performed, it can enforce that requirement by requiring covered individuals who do not follow the procedure to pay a greater share of the cost, even if that is higher than the percentage otherwise allowed for the guaranteed package. Similarly, it appears that a person who enrolls in a Preferred Provider Organization who elects, at point of service, to use a non-network provider would have the same co-pays and deductibles as people who enroll in a fee-for-service plan. That may not be enough to encourage adequate use of network providers. Another important point that needs attention is how coverages would coordinate when individuals or members of a family are entitled to benefits under more than one health plan.

12. It should be confirmed that a Labor-Management Alliance can offer its own self-designed health plan that provides the basic benefits through a combination of approaches, such as fee-for-service for major medical coverage, a PPO for hospitals and a prepaid mail-order plan for prescription drugs.

13. The test suggested for determining whether a Labor-Management Alliance is meeting its objectives under the national premium budget is unworkable and impossible to meet. An Alliance that operates its own plan, which is budgeted but not subject to strict advance

capitation, may not know until near or after the end of a year whether its total health care payments for that year are within the budget cap. As we understand the September 7 draft of the proposal, once an Alliance that had slipped over the cap for one of the two preceding years finds out that it has happened again the Alliance must dissolve and release its participants and contributing employers to their respective Regional Alliances. This is far too drastic, and leaves no opportunity for the Labor-Management Alliance to work with providers, health plans and others to bring costs under control. It also would create administrative chaos for the Labor-Management Alliance, its participants and the Regional Alliances that would be compelled to accept them with no advance warning or time for administrative preparation.

A more reasonable approach would be to give a Labor-Management Alliance several years (perhaps three, to coincide with bargaining-agreement cycles) to bring costs back within the targets, and to design flexible alternatives to help rehabilitate the situation rather than imposing capital punishment on a "first offender."

14. There is little detail on the concept of guaranty funds to reinsure the health plans. This is a point to which the Taft-Hartley fund community will be giving careful attention as the proposal evolves, to be sure the liabilities of those funds cannot grow to the point that their cost could threaten the soundness of on-going Labor-Management.

15. Finally, two issues regarding the tax status of Labor-Management Alliances and their participating funds should be clarified, to avoid subjecting the Alliances and funds to overlapping and potentially competing sets of regulations. First, it should be made clear that enterprises that meet the requirements for Labor-Management Alliances are automatically exempt from federal income tax under §501(c) of the Internal Revenue Code. Second, we object to allowing state and local governments to impose any taxes on Taft-Hartley funds or on their Labor-Management Alliances. ERISA's preemption of state laws was a central principle of that landmark federal law when it was passed; today it may be even more important for the ability of Taft-Hartley funds to provide high-quality and cost-efficient service for the families they cover.

C. Taft-Hartley Funds Within a Regional Alliance

As an alternative to establishing independent Labor-Management Alliances, multiemployer funds of any size might choose to help their participants qualify for health coverage and benefits through a Regional Alliance. A Taft-Hartley fund should be able to determine the level of its involvement. At the option of a fund's trustees, it might range from serving as the channel for the coverage under the Regional Alliance as if the fund were their employer, to providing support and assistance as an advisor to participants in their dealings with the new health care structure.

Much as employee benefit plans buy benefit coverage from insurance companies under

the current system, a Taft-Hartley fund could provide the legally-required standard benefit package on behalf of the contributing employers by "purchasing" this package through the regional Alliance or Alliances responsible for covering the plan's participants. Acting to some extent as an administrative intermediary for the Alliance, the plan could collect and reconcile the required employer contributions and maintain records on participants' service, enrollment status and coverage choices.

The law should give the Regional Alliances flexibility to negotiate arrangements for these kinds of services with Taft-Hartley funds. Thus, liability for premiums might be handled differently for different groups. A standard approach might be to preserve the underlying statutory liability of each individual employer, while enabling it to be met by the contributions the Taft-Hartley fund makes on behalf of its participants to the Regional Alliance, out of the pool of employer contributions to the fund. Under this approach it would not be necessary to determine and collect the specific amount that each employer would otherwise owe under the law, as long as the total amount paid for people covered by the Taft-Hartley fund at least equals the total amount that would otherwise have been due for them (taking into account applicable statutory caps and subsidies).¹

As at present, with the multiemployer plan serving as the vehicle for its participants' coverage through the Health Alliance, all service for contributing employers would be treated as service with a single employer. In this way, the employees would preserve their continuous eligibility for employer-funded coverage even as they move from job to job. It is absolutely essential that the service of multiemployer plan participants be aggregated in this way whether or not the plan serves as the intermediary, if those workers could otherwise lose entitlement to full employer-paid coverage because, given the mobile nature of their work, they move back and forth into part-time or unemployed status from time to time throughout a year. Using the Taft-Hartley fund as the umbrella mechanism for determining their employment status would also facilitate administrative and billing procedures for the Regional Alliance, if those functions are

¹ While the pool of negotiated employer contributions should cover all legally-required expenses, the employers that pay what they owe should be shielded from penalty if the total falls short because some employers are delinquent. This is comparable to the way the pension funding rules now work, for multiemployer plans, see Internal Revenue Code §413(b). Taft-Hartley fund contributions, which are typically made on a per-hour or per-day basis, are designed to fit the pay patterns of each industry and establish uniform labor costs for participating employers. Ordinarily, each employer whose employees are covered for a particular benefit package contributes at a uniform rate regardless of an employee's age, family status or need for dependent coverage. Taft-Hartley funds that provide supplemental health benefits will probably keep this approach. Premium assessments, collections and recordkeeping could be greatly simplified if it could also be followed in administering the employers' funding obligations for basic coverage.

not undertaken by the fund itself.

In general, employees enrolled for health coverage through a Taft-Hartley plan would have at least the same protections and opportunities as other employees. The Taft-Hartley plan might also assist its participants in dealing with the Regional Alliances and the health plans in which they enroll (e.g., claims disputes, support in seeking authorization for particular services or explaining why they are not authorized, communications about plan content and selection, problems with providers). This educational/ombudsman role should not only smooth the participants' path through the new health care structure, but it could also make the multiemployer plan a useful channel for employee communications on such matters as health promotion, wellness programs, evaluating providers, etc., which might be initiated either by the plan or by the Alliance.

Like other truly short-term employees, employees who earn some credit under a Taft-Hartley plan, but not enough for full coverage, could be covered directly through the Regional Alliance, or arrangements could be made for them to obtain full coverage through the plan by supplementing their employers' contributions on a self-pay basis, augmented by a government subsidy payable through the plan, to the extent the affected employers qualify as low-income or unemployed employees. Similarly, in maintaining their retiree coverage and extended health coverage for fully unemployed participants, Taft-Hartley plans can be the collection and documentation points for administering the subsidies for those groups. (Of course, as noted in connection with active employees, Taft-Hartley plans could provide assorted services in confirming eligibility and collecting and reconciling payments due from employers, employees or other parties, but would not be independently responsible for financing coverage for retired or unemployed participants unless they receive negotiated employer contributions for those people.)

In addition to making the standard Regional Alliance options available to their participants, it could be possible for Taft-Hartley plans to structure special packages that meet the special needs of their participants, which might be offered by one or more of the regular health plans or under a separate, dedicated plan provided through the Regional Alliance but available only to Taft-Hartley participants. For example, electrical workers may travel frequently during a year to work on projects at various locations throughout the country, while their families remain at home. This creates a special need for a combination of home and out-of-area coverage that enables both the worker and the worker's family to receive full health services in several geographically dispersed locations, which is not currently a common feature of most HMOs or other managed-care delivery systems. The multiemployer funds participating in a given Regional Alliance might arrange, with the Alliance's support, for one or more plans to add such a rider to its coverage package, for the multiemployer plan participants.

Many Taft-Hartley plans will be well positioned to serve as the vehicle through which basic benefits are provided to their participants through the Regional Alliances, using their

existing administrative apparatus both for this purpose and to continue delivering supplemental benefits. Combining the systems for providing basic and supplemental benefits would provide a cost-effective, integrated program to address all of an employee's health-related needs. Of course, it would also be appropriate to reimburse the Taft-Hartley plans for expenses incurred to provide enrollment, collection, employee communications and other administrative services for the Health Alliances, perhaps through an offset to administrative charges that the Health Alliances would otherwise assess, especially since the only other place the plans can look to for funds to cover those expenses would be the contributions negotiated out of the employees' pay package.

Chairman STARK. Thank you very much.
Ms. Owley, you are next.

STATEMENT OF CANDICE OWLEY, VICE PRESIDENT, AMERICAN FEDERATION OF TEACHERS, AFL-CIO, AND CHAIR, FEDERATION OF NURSES AND HEALTH PROFESSIONALS

Ms. OWLEY. Thank you, Mr. Chairman.

My name is Candice Owley. I am the vice president—

Mr. KLECZKA. Mr. Chairman, before the witness begins, I would like to chime in here and add a special welcome to Candice, who is from my city, Milwaukee.

In addition to being Chair of the Federation of Nurses, she also has another task, unpaid, sorry to say, and that task is she is a member of my health advisory board in the Fourth Congressional District, a very smart and contributing member. I thank you for your efforts on that behalf, also.

Chairman STARK. Does she live in Wauwatosa?

Mr. KLECZKA. No, she is not from the chairman's birthplace of Wauwatosa. She is a Milwaukeean.

Chairman STARK. Later, later.

Ms. OWLEY. Thank you, and thank you, Congressman Kleczka.

As I said, I am both the vice president of the American Federation of Teachers and chairperson of the Federation of Nurses and Health Professionals, which is our health care division. I am also a registered nurse.

AFT certainly welcomes your personal efforts, Mr. Chairman, and the leadership of the President. In fact, I was going to add, as a resident of Milwaukee, that we certainly appreciate Congressman Kleczka's leadership on this critical issue on behalf of the citizens of my community.

AFT is a national union affiliated with the AFL-CIO. We represent over 830,000 members who work in public elementary, secondary schools, higher education, State and local governments, and in my case, in the health care system. The 2,200 AFT-affiliated local unions maintain over 1,900 collective bargaining agreements and negotiate more than 800 new agreements each year.

Our locals are on the front line of the health care crisis as they bargain or lobby for health care benefits. They have come to rely on their local contracts to provide the health coverage for themselves and their families, and they have a vital interest in the development of the national health care reform legislation before you.

Because of our beliefs and concerns about health care, in fact, in 1988 I chaired a commission within our own union to study the issue of the future of the health care system. In 1990, we adopted a resolution at our convention which set up basic principles that we believed in and that should be incorporated in any health plan.

We were very pleased when the President's plan was released to find that the union's principles that were developed over 3 years ago and adopted by our convention were, in fact, reflected in the President's proposal. This shared vision of the underpinnings of a reformed health care delivery and financing system earned AFT's support for the President's plan. In fact, this week, just the day before yesterday, I believe, our executive council did endorse the current plan that has been released.

As this plan is translated into details and legislative language and is subject to rigorous Congressional debate, our members will work with you, of course, but we will also work hard to defend the principles and our members' interest at the same time.

The availability of affordable health care has had a very serious impact on the lives of our members, both their personal lives and, in many ways, their lives as professionals. Our members that are in the education system, not only does it impact on them but it impacts on the children that they teach because of the unmet health care needs and their inability to learn. Also, our health care members who work in the system struggle on a daily basis to help patients deal with a complex, sometimes indifferent system, that now exists.

In order to achieve such a system, our society must meet four simultaneous objectives: Choice of provider, universal access, cost control, and improvements in quality of patient care. We believe failure to address any of these goals will lead either to more cost shifting or less access to care.

In order to move ahead and not waste any time, I would like to, however, move to a number of specific concerns that we have that I would like to share with you.

The first is that public employers and employees ought to be treated the same as private employers and employees in all aspects of health reform. In that regard, we mean that if private employers with 5,000 or more employees can form their own alliance, then we believe public employers also should be able to have that same opportunity. Of course, we also believe that applies to the proposed payroll cap. If it applies to the private sector, it should apply to the public sector.

We also believe that the second issue is the Federal and State Government should immediately provide transition benefits to health care workers who are already losing their jobs. Nurses and other health-related personnel are being laid off now as administrators are shaving costs and sacrificing, we believe, quality of patient care in the name of transitioning to the new system.

We ask that Federal and State authorities provide transition benefits for affected health care workers that would include job placement services, moving allowances, supplemental income for 6 months, and training and retraining programs.

The Federal Government should also require a hospital to file an employment impact statement with the state insurance commission before a layoff could take place. A hospital would have to demonstrate that the layoff would have no impact on the quality of patient care in their community in order to be approved.

In addition, we believe Federal and State authorities should require hospitals to publish nurse and related personnel staffing ratios so patients can rate hospitals by this standard. We hope that once reform is implemented, these nurse staffing ratios are included in the consumer scorecard.

We also believe the definition of part-time work needs to be defined in such a way that it ensures all part-time workers receive a fair premium. Many of our members work in colleges part time and are university faculty that teach less than the 10-credit hours, which is the floor that was currently being considered. If the floor

is kept at 10, thousands of these workers will be denied any employer contribution toward their health premium.

A related problem deals with the prorated contribution and the definition of full-time work. Full-time work of 40 hours is not always the typical definition. We even know, to skip to some of my nurse members, they have the weekend programs where they work two 12-hour shifts on a weekend, and that is considered full time by their employer. That definition has to be looked at.

We think that the schools should not be permitted to shift their share of health care premium for personnel who are working the summer months. This applies not so much to the teachers but to clerical and bus drivers, workers, and so on. They should be considered full-time workers, not seasonal or part time when they are off in the summer, and their employers should be required to provide that contribution.

Obviously, we believe the tax-free status of health benefits is important.

I would like to go on to say that the employees should continue to retain the right to bargain with their employer over the health care costs, but in particular, we are concerned that if your employer sets up an alliance, either a corporate or public alliance, that the unions should have a say over which plans are going to be offered through a separate alliance and what the structure of that alliance should be.

We know that there needs to be special attention given to medically fragile children and the health care needs within the schools, and ask that that area be looked at and be sure to be included.

We would like to stress that the makeup of the governing board in the health care alliance is of great importance to us and recommend that only employers, consumers, unions, and public officials be eligible for membership. We believe that public officials should only have a minority representation on these boards, particularly because they are probably going to be the ones appointing these boards, and that the providers should be actually excluded from membership.

Finally, and I guess this somewhat goes to Congressman Kleczka's point, we know that the health care use and costs directly relate to age, and so we are very concerned about the early and normal retiree health care coverage and believe that it is essential. Half of our members have no employer-provided insurance, and those that have it pay half of their premiums.

Retirees with minimal pensions who have no employer-provided insurance really suffer severe economic hardships, and we believe this is especially true of single women. I use the example of a recently retired nurse from St. Francis Hospital in South Milwaukee, whose pension, after 17 years of full-time work, I might add, is approximately \$200 a month. For her to have her health insurance, she will have to pay over \$600 for her premium. We believe that adding this in and having this covered by the government is critically important for the health and well-being of these retired members.

I will stop there and thank you for the opportunity to present our views.

[The prepared statement follows:]

TESTIMONY OF CANDICE OWLEY
VICE-PRESIDENT, AMERICAN FEDERATION OF TEACHERS
BEFORE THE SUB-COMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

OCTOBER 28, 1993

Mr. Chairman, I am Candice Owley, Vice-President of the American Federation of Teachers and Chair of the Federation of Nurses and Health Professionals - the AFT health care division. I am also a registered nurse. As you are aware, the AFT welcomes your efforts and the leadership of President Clinton as our nation tries to deal with this critical issue.

The AFT is a national union affiliated with the AFL-CIO. We represent over 830,000 members who work in public elementary and secondary schools, higher education, state and local government and, in my case, the health care system. The 2,200 AFT affiliated local unions maintain over 1,900 collective bargaining agreements and negotiate more than 800 new agreements each year. Our locals are on the front lines of the health care crisis as they bargain or lobby for health care benefits. Our members have come to rely on their local contracts to provide health coverage for themselves and their families. They have a vital interest in the development of the national health care reform legislation now before you.

Because of our beliefs, delegates to our 1990 convention adopted "The Future of Health Care Resolution" which sets out the basic principles that should be incorporated in any health care reform plan. These principles include choice of provider, universal and portable coverage, real cost containment, improvements in the quality of care and administrative simplification. A copy of that resolution is attached to this statement for review and consideration. (See Appendix I)

The principles that our union developed over three years ago are consistent with the principles advanced by President Clinton in his September 22, 1993 address to the nation. This shared vision of the underpinnings of a reformed health care delivery and finance system has earned AFT support for the President's plan. As this plan is translated into detailed legislative language, and is subject to rigorous Congressional debate, AFT members will work hard to defend the plan's principles and our members' interests.

The availability of affordable health care has an impact on every aspect of our lives. It affects our members' personal lives as providers, consumers, patients, parents and children of elderly parents. It directly affects our members' standard of living. It has an impact on our teacher members who try to educate children who come to school with unmet health care needs that impair their ability to learn. And health care affects us as taxpayers. Health care reform will also affect health care professionals who struggle to help patients deal with the current complex and sometime indifferent system of care that now exists. Because the health care system is so intertwined with our everyday lives, we who work in it are aware of how confusing the existing delivery and finance mechanisms are. We agree with other members of our union who do not work in health care that these essential systems that have served our society for more than 40 years are now in need of fundamental reform.

THE AFT'S VISION OF HEALTH CARE REFORM

We need a delivery system that puts people first. We need a system that controls costs. A system that provides the right care at the right time in the right place for every citizen. A system that melds consumer and provider values into a new social

contract that will stand the test of time. A system that distributes the financial burden in a fair and equitable manner. A system that is self-driven to improve the quality of care.

In order to achieve such a system, our society must meet four simultaneous objectives, and they are: choice of provider; universal access; cost control; and improvements in the quality of patient care. Failure to address any one of these goals will lead to either more cost shifting or less access to care. For example, mandating universal coverage would add an additional 37 million people to the insurance rolls. Without cost containment, utilization of medical services would expand and so would total costs. Proposals that exclusively concentrate on improving the quality of care would encourage more cost shifting over the development of practice guidelines. Cost containment without universal access would pit the public and private sectors against each other over the cost of the uninsured. Choice of provider ensures consumers of a large pool of care givers to meet individual and family needs.

Health care reform and economic revival are compatible goals. If costs can be controlled, consumers, governments, and business will have more money for investment in our future. Providers will also benefit through a national bonding of values that will make quality of patient care, rather than revenue or liability protection, their top priority.

One additional principle that was not stated in our resolution, but forms the basis for several important issues of particular concern to our members is fairness. We want health care reform to treat our members fairly and not single them out for disparate treatment. In this context, we advance the following specific concerns for consideration.

1. Public employers and employees ought to be treated the same as private employers and employees in all aspects of health care reform. If private employers, with 5,000 or more employees, can form their own alliances, then public employers, with 5,000 or more employees ought to have the same opportunity. This concept should also apply to the proposed payroll cap. Public employers, and ultimately public employees, should not be asked to pay more for health care than private employees or their workers.

2. Federal and state government should immediately provide transition benefits to health care workers who are already losing their jobs. Nurses and other related personnel are being laid-off right now as administrators are shaving costs and sacrificing the quality of patient care in the name of transitioning to the new system. The diminution of quality care should not be acceptable to the public. It is not acceptable to us.

Federal and state authorities should provide a transition benefit for affected health care workers that would include job placement services, a moving allowance, supplemental income for up to six months and training and retraining programs. The federal government could also require a hospital to file an employment impact statement with the state insurance commission before a layoff can take place. The hospital would have to demonstrate that the layoff would have no impact on the quality of patient care in order to be approved by the commission. Alternatively, federal and state authorities could require hospitals to publish nurse and related personnel staffing ratios, so patients can rate hospitals by this standard. Once the reform plan is implemented, nurse staffing ratios should be included on consumer score cards.

3. The definition of part-time work needs to be defined in such a way that ensures all part-time workers receive a fair premium share from their employer. Many AFT-represented part-time college and university faculty teach less than the 10 credit hours per-week floor that is being considered the minimum number of hours needed to qualify for an employer payment.

If the floor is kept at 10 hours, thousands of these workers will be denied any employer contribution toward their health premium. This would be especially onerous on part-time faculty who teach at several different institutions and earn the equivalent of a full-time salary.

A related problem deals with the level of the prorated contribution, and the definition of full-time work. A typical full-time work schedule for college and university faculty is 12 to 15 class hours-per-week. Therefore, the employer's prorated share contribution for part-time faculty ought to be based on the full-time faculty class hours. Similar types of definitions may also be needed for part-time faculty and related personnel at elementary and high schools, nurses and others whose typical full-time work schedule is other than 40 hours-per-week.

4. Schools should not be permitted to shift their share of the health care premium for personnel who are off in the summer months. Under the proposed plan, "regular seasonal workers" like cafeteria workers, bus drivers and office clerical would be considered unemployed during the summer and eligible for federal assistance. These workers should be treated the same as teachers and be eligible for a year-round health care contribution from their employer.

5. The tax-free status of health care benefits should be continued. Our members have given up real wage increases just to maintain health coverage for their families. It would not be fair to now ask them to pay an extra fee for maintaining coverage.

6. Employees should continue to retain the right to bargain with their employer over health care costs and benefits. Unions should have the right to bargain over the creation of a corporate or public alliance. Health care reform should not provide an employer any new authority to circumvent the collective bargaining process, any signed contract or the right of a union to represent its members.

7. Special attention should be directed to medical, nutritional and social needs of children. Health care alliances should be directed to review the health care needs of children and develop and update an impact statement on how they will meet their needs. Particular attention should be given to the health and learning needs of the "fragile child" and children with other learning disabilities.

Health care alliances should be directed to work with state, county and city school and public health officials, teachers, school nurses and aids to develop school-based clinics where it is appropriate to do so. All employers, consumers, health care plans, and alliances should provide necessary financing for these entities. The National Health Board should include the cost of these clinics in the development of alliance budgets.

8. The makeup of the governing board of the health care alliance is of great importance to us. We recommend that only employers consumers, unions and public officials be eligible for board membership. Public officials should only have minority representation on these boards and providers of health care should be specifically excluded from membership. Both public officials and providers have an inherent conflict of interest, that would jeopardize arms-length bargaining with health care plans.

9. As senior health care use and costs are directly related to age, early and normal retiree health care coverage is essential. One-half of AFT-represented retirees have no employer-provided insurance and of those that have insurance, only one half are eligible for employer payments. Moreover, retirees with minimal pension benefits who have no employer-provided insurance suffer severe economic hardship. This is especially true of single women. For example, a recently retired nurse from St. Francis Hospital in South Milwaukee reported that her monthly pension is \$200 while she must pay \$600 a month for an individual health care policy.

We are attaching information on the extent of AFT member health care coverage and how health care directly affects our members as workers, teachers and school-based health providers for your review. (See appendix II) We will submit additional information on the coverage and impact of the health care crisis on our members who work in the health care industry.

APPENDIX I

THE FUTURE OF HEALTH CARE*

WHEREAS, union members have historically enjoyed comprehensive health coverage requiring little or no personal financial contribution, but spiraling health care costs have resulted in efforts by employers to shift costs to employees through higher deductibles, co-payments and diminished coverage; and

WHEREAS, efforts by the federal government to control health care costs have restricted hospital admissions to acutely ill individuals and significantly shortened hospital stays; and

WHEREAS, a severe shortage of health professionals affects their ability to deliver the quality of care patients deserve and ultimately affects the health and well-being of society as a whole, the leadership of FNHP requested that the AFT executive council appoint a Task Force on the Future of Health Care to analyze current conditions, explore proposals and make recommendations; and

WHEREAS, the Task Force formed in July 1988 conducted an extensive investigation through presentations by policy experts who focused on the issues of cost, access and quality.

The Task Force found that:

Health care costs in the U.S. have risen from 7.2 percent of the gross national product in 1972 to 11.2 percent in 1987. On the other hand, countries with nationalized health care have been far more successful

in controlling their health care costs. For example, in 1970, Canada finalized implementation of its national health care system. Their costs rose from 7.2 percent in 1970 to 8.6 percent in 1987. Other industrialized nations like Japan, France, Germany and Great Britain have kept costs in the range of 6.1 to 8.6 percent also. Health care spending in the U.S. has become disproportionate to the percentage of spending for both education and defense, which has, in fact, dropped from 1970 to 1987.

Increased spending on health care has not brought coverage to more citizens. Some 30 million to 37 million Americans are uninsured, and over 50 million are underinsured and would be made bankrupt by catastrophic illness. Of those uninsured, approximately two-thirds are employed or dependent on someone who is but have no coverage through their job. One in five is a child.

Federal provisions for the poor and elderly, Medicaid and Medicare, have been less than adequate. Bureaucratic processes make application for Medicaid difficult, and stringent rules have left the "working poor" unable to qualify for health coverage. In addition, nearly 46 percent of Medicaid dollars are now being spent to finance long-term care. Seniors spend 18.2 percent of their income to compensate for what Medicare does not cover.

Geographic maldistribution of health care facilities and health professionals is significant in many rural and some urban areas and impedes access to care for those residing there. In addition, cultural differences and language barriers also result in access problems.

Although the U.S. spends more than any other nation on health care, many question the quality of care purchased for the health care dollar. Infant mortality in the U.S. is higher than in any other industrialized nation.

American medical care also lacks standard treatment protocols. Medical practices vary from physician to physician and state to state. Data are now being collected to help define the practices that yield the best results and also monitor the cost effectiveness of various treatments. Early information shows that high cost is almost always an indicator of inappropriate or excessive treatment. Shortages of health professionals have forced hospitals to close beds or use personnel inadequately trained to deliver care.

National surveys show that Americans strongly support sweeping reform. This conclusion has also been reached by the Task Force on the Future of Health Care, and the resolves that follow comprise statements of principles and strategies believed to define cost-effective, high-quality health care for all Americans:

RESOLVED, that the AFT endorse reform of the health care system that encompasses the following principles:

Health care cost containment is a priority and should be accomplished by:

- establishing a single payment system for all basic services to prevent cost shifting and reduce administrative expenditures;
- setting national caps on health care spending;
- monitoring and eliminating duplicative or unnecessary

services and technologies on a national, state or local level;

- establishing a national data bank to collect and disseminate information on health care costs and quality and on the cost effectiveness of treatments and medications;
- encouraging and reimbursing preventive care;
- providing incentives that reward health care providers and health care systems that demonstrate they can deliver high-quality, cost-effective care;
- establishing state coordinating bodies comprising consumers, unions, businesses, ethicists, providers and government to create and monitor incentive programs and quality indices and coordinate capital investment and expenditures based on community needs;
- focusing resources on health promotion, health education and disease prevention to reduce illness, high-risk behavior and unnecessary institutionalization; and
- supporting safe and healthy workplaces and strategies for environmental protection and cleanup.

Uniform high-quality health care services are vital and should be accomplished by:

- recruiting adequate numbers of health professionals to maintain the ability to deliver high-quality care;
- collecting and publicly disseminating data on treatment outcomes, by facility and by practitioner, and consumer attitudes about their quality of life after medical treatment;
- establishing standards of medical practice and clinical guidelines to be used as a basis for high-quality health care and as a means to reduce the incidence of malpractice;
- promoting systems of managed care and case management that monitor and coordinate care of individuals to reduce fragmentation of services, ensure access and control costs;
- preserving consumer freedom of choice of providers and setting of care; and
- promoting health education as an integral part of any treatment or intervention, as a means to foster appropriate behaviors that prevent or reduce illness and provision of health education should be encouraged in community settings, through the media, in the schools and workplaces.

Individuals should have universal access to a basic national standard of high-quality care including preventive, acute, prenatal, mental health, long-term and rehabilitative care and drug therapies prescribed as part of the treatment. Such access should be fostered by:

- eliminating financial barriers to care;
- promoting expansion of existing community-based health centers and development of new centers for use by all consumers;
- promoting utilization of nurses and other health professionals as primary providers;

- ensuring portability of health care coverage and providing protection when moving between jobs or states;
- providing financial incentives such as loan forgiveness or free education to ensure adequate supply of health professionals especially in underserved or shortage areas;
- encouraging health systems that improve access through flexible hours and by providing both transportation and child care services;
- supporting mobile clinics and school and workplace clinics;
- providing translation services in any health care setting where English is not the primary language and providing cultural awareness training for health professionals;
- providing broad based programs to pay for long-term care that will not require spending down of personal assets;
- supporting home and community based alternatives to institutional long term care available to all ages;
- supporting long term care eligibility requirements other than individual inability to perform three legislatively defined activities of daily living;
- providing training, support and respite care for family members and others participating in home care; and
- supporting health care systems that demonstrate high retention and job satisfaction rates for health professionals and health care workers; and

RESOLVED, that the AFT prepare educational material for members regarding problems with the health care system and the need for national reform; and
 RESOLVED, that AFT update its material on negotiating health care benefits and cost containment; and
 RESOLVED, that AFT research the impact on the education system of skyrocketing health care costs and declining health status of children; and
 RESOLVED, that AFT continue its support of the AFL-CIO strategies for national health reform; and
 RESOLVED, that AFT develop its own grassroots campaign to educate and involve members in change; and
 RESOLVED, that AFT research the impact of the severe nursing and allied health professional shortage on the quality of health care services; and
 RESOLVED, that AFT create a committee on health care reform comprising representatives from all AFT divisions to provide guidance on methods to reduce health care costs and reform the health care system. (1990)

* This resolution incorporates a summary of the findings along with the complete recommendations of the Task Force. The entire Task Force report was adopted by the council as a resolution at its April 1990 meeting.

CHARACTERISTICS OF AFT MEMBER HEALTH COVERAGE AND HOW IT AFFECTS OUR MEMBERS

About 90 percent of our full-time membership are provided medical care benefits. About two-thirds receive dental care and one-third are eligible for vision care. The typical medical indemnity plan covers such major items as hospital room and board, physicians' visits in the hospital, surgery, x-ray and lab services. Covered outpatient services usually include physician office visits, mental health visits and prescription drugs. Among benefits less frequently provided are hearing care, routine physicals, well baby care and immunizations.

In 1990, about three-fifths of our membership participated in a traditional fee-for-service basic and major medical plan. About one-fifth of the membership received care through a Preferred Provider Organization and another 20 percent belonged to Health Maintenance Organizations. One hundred dollars (\$100) was the most prevalent deductible in the traditional indemnity plan, but the average deductible was \$167. Recent trends show that the deductible is moving up to the \$200 level rather quickly. Nine out of ten members paid a co-insurance amount for major medical coverage and the most common amount was 20 percent.

Approximately one-third of our members contributed a portion of the 1990 employee-only premium and the average cost was about \$25 per month. About two-thirds of our members contribute toward the family plan and their average 1990 monthly contribution was about \$150. Since 1990 both the number of members and the share of the health premium that they pay has increased.

About one-half of our retired members are covered for health benefits either before or after age 65 and one-half are not covered. For those that are covered, about one-half enjoy full employer paid coverage. The other half of retirees share in the cost of care.

Since most of our members receive health insurance and broad coverage some wonder why we would be interested in health care reform. However, a review of the distribution of wage and benefit changes over time shows that the maintenance of medical benefit plans have come largely at the expense of wage increases.

HEALTH CARE AFFECTS OUR MEMBERS' STANDARD OF LIVING

Over the 1970-1990 period real average member total compensation grew by about 13 percent. During that time real average wages increased only about 8 percent while benefit spending grew by over 60 percent. The primary reason for the rapid growth in benefit spending was the over 150 percent increase in group medical insurance costs over this period.

In the 1970's wages represented about 85 percent of a typical member's total compensation and benefits represented about 15 percent. By 1990 the distribution had changed to approximately 80 percent wages and 20 percent benefits. If current trends continue, employee benefits could constitute over one-fourth of a member's total compensation by the turn of the century. This means that about another \$5,000 per member will be shifted from potential wages to health benefits between now and the end of this decade.

Current contract activities reinforce these trends. For example, Milwaukee County nurses went six months without a contract then accepted a one-year wage freeze in order to maintain their health benefits. Baltimore teachers and paraprofessionals accepted a one-year wage freeze to protect their health benefits. And Chicago Teachers recently agreed to pay part of the health care premium at the same time they accepted a two year wage freeze. Prior to this agreement, the School Board paid 100 percent of the health care premium.

HEALTH CARE AFFECTS OUR MEMBERS AS EDUCATORS
AND HEALTH SERVICE PROVIDERS IN THE SCHOOLS

As educators, our members directly experience the impact of the health care crisis on student readiness to learn. Our teachers, school nurses and paraprofessionals see students every day who are in need of basic preventative services including dental and vision care. According to the U.S. Center for Disease Control, about one-third of children between the ages of 1-4 and one-fourth of those 5-14, do not receive basic childhood vaccinations that are the first line of defense against serious disease. However, the medical needs of these students are typically ignored, because their parents are uninsured and unable to get the care that their children need.

Much of this neglect is due to the fact that about 10 million children (about one-third of the uninsured) do not have health insurance. However, many children also come to school with preventable conditions that increase the risk of learning impairment. The most common of these risks are: (1) low birth weight; (2) prenatal exposure to smoking, alcohol and drugs; (3) lead poisoning; (4) child abuse; and (5) malnutrition.

A recent study in New York City shows that school children are suffering a rising number of health problems due to the lack of access to basic medical care. For example, 23 children died from measles between 1990 and 1991, and the number of reported cases in 1991 was 40 percent above the 1990 level of 2,500. This reflects a national trend which has shown an alarming growth in measles cases. The reported 89 deaths attributed to this preventable disease in 1990 was the highest number reported in 20 years.

Another growing problem is the rise in the number of handicapped students. Between 1980 and 1987 the number of public school students with a learning disability rose by 50 percent. There has also been a rise in "medically fragile" students; those who require catheterization, tube feedings, injections, or oral medications to maintain body functions. While school nurses have typically been responsible for providing care to these children, their jobs are being eliminated due to budget cuts, and care is being passed on to the teacher. In Rochester, New York, the county cut the number of nurses and health aides by 20 percent and shifted the responsibility to teachers and other school personnel. Boston is experiencing a similar fate, since almost 40 percent of its public school nurse force was laid off while school enrollment rose by 5,000 students.

Mr. McDERMOTT [presiding]. Thank you very much.
Mr. Chase.

STATEMENT OF ROBERT CHASE, VICE PRESIDENT, NATIONAL EDUCATION ASSOCIATION

Mr. CHASE. Thank you very much. My name is Bob Chase and I am vice president of the 2.1 million member National Education Association. I am proud to have an opportunity be a witness here today at this first set of hearings following the release of President Clinton's health care reform proposal.

We applaud Chairman Stark and the members of this subcommittee for their leadership on the issue of health care, and we commend President Clinton for bringing health care reform to the nation's agenda and for developing a proposal that addresses delivery, access, and cost. The administration's proposal must be the starting point for health care reform.

NEA members have a unique perspective on the issue of health care. As educators, we are concerned about the impact on children of the present inadequacies in the system. As advocates of educational excellence, we are concerned about the competition for resources between education and health care, and as middle-income Americans, we are concerned about the issue of health care as it affects our own families.

NEA believes that access to affordable, comprehensive health care is a right of every citizen. Our goal is a single-payer health care plan for all legal residents of the United States. We will support health care reform measures that move closer to this goal and that first achieve universal access to comprehensive health care coverage; second, control costs while assuring quality; and third, emphasize prevention of health care problems.

Each day, NEA members work with children who suffer from a wide range of treatable and/or preventable medical conditions. At least 10 million children under 18 have no health insurance, no continuity of care, no access to preventive treatments. Inadequate health care coverage is a serious obstacle to achieving the national education goals.

The administration's proposal for a universal guarantee of a comprehensive benefits package with an emphasis on preventive care is an important step toward real and lasting improvement in our health care system.

The final form of any health care reform bill must assure true universality, and Congress must provide the resources and mechanisms to make quality health care services affordable to every American.

Further, we strongly support the provisions of the administration's plan that would provide funding for comprehensive school health services and training for school-based health personnel.

NEA members are deeply concerned that growing costs of health care detract from the government's ability to provide adequate resources for education. In 1960, spending for health care was about one-fourth of the amount spent for education. By 1990, health care spending was nearly twice as much as education spending.

We believe single-payer plans can be an effective means of controlling costs and ensuring full access to services. The administra-

tion's most recent proposal eliminates barriers to States adopting a single-payer plan within the State. These provisions must be included in any final legislation.

Another way to assure that costs for public employers do not grow out of control is to provide the same cap on premium costs for public and private employers, not as a phasein, from the beginning.

We also strongly support the proposed cap on employee premiums and believe such a cap should not go beyond the 3.9 percent suggested.

We strongly support provisions of the administration's plan that would maintain for 10 years the tax exemption for health care benefits that go beyond the guaranteed plan. Section 125 plans should be maintained in the same way.

The administration's plan would impose Medicare payroll tax on all public employees, a change we have opposed for a number of years. We fear that many State and local employees will be subject to this tax and yet not be able to qualify for services. Therefore, all public employees should be deemed qualified for Medicare coverage on reaching the age of 65, provided they have worked 40 quarters, regardless of whether or not all 40 quarters were Medicare-covered employment.

In order to minimize disruption and build on successful existing structures, large public entities should be able to form separate alliances if they are acting in the same manner as an alliance and enroll more than 50,000 members.

We recognize that this hearing is held early in a process that can be expected to take months. The issue is, indeed, complex, the stakes are high, and the interests of various affected individuals and institutions will often be in conflict. And yet, the time for health care reform has come.

NEA pledges to work with this administration, this Congress, and all other Americans who will support a plan that is comprehensive, responsible, and compassionate.

Thank you very much.

[The prepared statement follows:]

**STATEMENT OF ROBERT CHASE, VICE PRESIDENT
NATIONAL EDUCATION ASSOCIATION**

Mr. Chairman and Members of the Subcommittee:

I am Robert Chase, Vice President of the 2.2 million member National Education Association, which represents education employees in the nation's public elementary, secondary, vocational, and postsecondary schools. I appreciate the opportunity to speak with you about an issue of vital importance to the nation's children and to all Americans: health care reform.

I am proud to be a witness today at this first hearing following the release of President Clinton's health care reform proposal -- a plan that is action item one for this Congress and this nation. The people have spoken. The time for health care reform has come. And the NEA pledges to work with this Administration, this Congress, and all other Americans who will support a plan that is comprehensive, responsible, and compassionate.

In September 1986, NEA testified before the Select Committee on Aging on the United States Health Act, offered by Rep. Edward Roybal of California. This legislation -- which would have expanded access, assured quality, and controlled costs -- was introduced, one hearing was held, and no other substantive action was taken. In the view of most Members of Congress, national health care reform was simply not a priority.

What a different world we live in today. Rather than saying we can't afford health care reform, the consensus among most Americans is that we can't afford not to institute comprehensive changes in our health care system. We applaud Chairman Stark and the Members of this Subcommittee for their leadership on the issue of health care.

Moreover, we commend President Clinton for bringing health care reform to the nation's agenda and for undertaking the formidable task of developing a proposal that addresses the many problems that exist in delivery, access, and cost. The Administration's proposal must be the starting point for health care reform. We are heartened by Congress' willingness to take this issue on, and we pledge to work with you to preserve and strengthen the essential elements of the President's plan. Attached to our testimony is a copy of a statement of principles on health care reform, adopted by some 8,000 delegates to our Representative Assembly in June 1993.

NEA believes that access to affordable comprehensive health care is a right of every citizen. Our goal is a single-payer health care plan for all residents of the United States, its territories, and the Commonwealth of Puerto Rico. We will support health care reform measures that move the U.S. closer to this goal and that achieve universal access to comprehensive health care coverage, control costs while assuring quality, emphasize prevention of health care problems, and are financed by means that assure greater equity in the funding of that health care.

The Clinton Administration's proposal for a universal guarantee of a comprehensive benefits package is an important step toward real and lasting improvement in our health care system. In particular, we support the comprehensive benefits package with its emphasis on preventive care, the options for coverage, the guarantee of coverage and continuity, and cost controls. Universality means more than access in theory; Congress must provide the resources to make access to quality health care services affordable to every American.

NEA members have a unique perspective on the issue of health care. As educators, we are concerned about the gaps in the present system and the impact those inadequacies have on public school students. As individuals committed to

enhancing the quality of public education, we are concerned about the growing share of our nation's resources that health care costs consume, especially inasmuch as they detract from governments' ability to provide adequate resources for education. And as public employees, we have experienced the same challenges as other middle-income Americans in being able to afford adequate coverage for ourselves and our families.

Health Care, Children, and the Future

By the most conservative estimates, at least one-third of the 37 million Americans with no health care coverage are children. Inadequate health care coverage is a serious obstacle to meeting the National Education Goals, particularly in the areas of readiness and student achievement. Too many children suffer from learning disabilities that are the result of inadequate prenatal care or from treatable medical conditions that go untreated because their families have little or no health care coverage.

Over the past decade, as health care premiums skyrocketed, many families have had to resort to health care coverage that provides assistance only for catastrophic conditions. Each day, our members work with children who suffer from a wide range of medical conditions that are treatable and/or preventable. Yet too many Americans now rely on hospital emergency wards as primary health care providers. As a result, they have no continuity of care or access to preventive treatments.

Health care costs and health insurance premiums rose sharply over the past decade, while average incomes fell. Employer-provided full family coverage is no longer a given. As unemployment rose, employers cut back on coverage and expanded cost-sharing. Individual coverage -- outside of a group plan -- became financially unattainable for most Americans.

The costs to families who lack health care coverage are great, but the costs to our society -- in both financial and human resources -- is monumental. A planned program of health care, including prenatal care, inoculations, well-baby care, and regular check-ups is not merely cost effective; it is an investment in our human resources and our nation's long-term economic and national security. The Clinton Administration's program takes these needs into account, and as such deserves the strong support of Congress.

We strongly support the provisions of the Administration's plan that would provide funding for school-based health clinics, comprehensive school health services, and training for school-based health personnel. Public schools can play an essential role in promoting health through education and screening, but schools must be provided the resources to perform those functions effectively.

Health Care and Education: Competition for Resources

NEA members are well aware of the impact of rising health care costs on governmental budgets. Over the past two decades, health care costs have absorbed a steadily growing share of resources at the state and local level. We strongly support responsible measures to reduce health care costs, especially in areas of waste, overregulation, and fraud.

In 1960, spending for health care was approximately \$27 billion, about one-fourth of the \$103 billion spent for all education -- public and private, elementary, secondary, and postsecondary. By 1990, health care spending, at \$666 billion, was nearly twice as much as education spending, at \$365 billion.

State and local governments bear the responsibility for health care services in various ways. As employers, they shoulder the costs of coverage for more than 15 million employees. States share the costs of Medicaid with the federal government, and according to the National Governors' Association, Medicaid costs have risen an average of 26 percent each year over the past three years. Many state, county, and municipal governments also provide direct health care services, including support for hospitals, clinics, outreach programs.

As the Members of this Subcommittee are well aware, Medicare and Medicaid costs have mushroomed in recent years. Total public expenditures for health care rose by 269 percent between 1980 and 1990. Medicare and Medicaid costs rose from almost 63 percent of public health care expenditures to more than 67 percent. By comparison, public expenditures for child and maternal health declined from 0.08 (eight one-hundredths) percent to 0.07 (seven one-hundredths) percent over the same period.

Unless health care costs are brought under control, health care expenditures are expected to consume the lion's share of public resources. The National Governors' Association projects that Medicaid costs alone will consume 22 percent of total state budgets by 1995. Between 1980 and 1992, Medicare costs rose from 5.4 percent of the total federal budget to 8 percent; other health care spending rose from 3.9 percent of the total federal budget to 6.4 percent.

To assure that costs for public employers do not grow out of control, it is critical that the 7.9 percent cap on payroll set for private employers also apply to public employers. At present, local school districts in seven to 10 states would exceed the 7.9 percent cap on health care premiums. The Administration's plan would phase in the cap on employer premiums; public employers should be treated equally in this regard from the first day of implementation.

NEA supports health care reform that will bring costs under control without diminishing quality or rationing services. Other industrialized nations -- most of which provide a much greater share of health care costs through public providers -- have proven it can be done. As the following chart illustrates, health care costs have risen much more slowly among our major economic competitors.

	1980	1990	public
U.S.	9.3%	12.4%	42%
Japan	6.4%	6.5%	71%
France	7.6%	8.9%	73%
Italy	6.9%	7.7%	71%
U.K.	5.8%	6.2%	85%
Germany	8.4%	8.1%	73%

The relative share and stability of health care costs among these nations would seem to argue for single-payer plans. Consequently, we believe that there should be no disincentive to states wishing to adopt a single-payer system. The Administration's most recent proposal eliminates barriers to states adopting a single-payer plan within the state, and these provisions must be included in any final legislation.

Health care reform, without meaningful cost controls, will only exacerbate the strains at the state and local level to address health care needs, education improvement and renewal, and other pressing demands.

Education Employees and Health Care Benefits

Like all Americans, NEA members are concerned about the nation's health care system from the standpoint of its impact on themselves and their families. A 1991 study by NEA compared the level of benefits provided public school teachers, other public employees, and persons employed in the private sector.

According to the U.S. Department of Labor, 37 percent of all teachers are required to contribute a portion of the premium for individual coverage, compared to 44 percent in the private sector. But teachers are much more likely to have to contribute for family coverage, by 73 to 64 percent, and their monthly contribution for family coverage is generally greater than among private employees.

Health care costs have grown considerably, as a share of average teachers' salaries, in recent years -- constraining the ability of school districts to provide the salary increases necessary to attract qualified teaching candidates. Between 1984 and 1989, health care costs rose from 7.7 percent of the average teacher's salary to 9.9 percent.

We are concerned that health care reform not worsen the economic pressures on school districts or education employees. Two circumstances of the public schools require some protection against an undue increase in the individual's share of health care premiums. Public employees include a number of part-time staff, both instructional and non-instructional, and public employees, including teachers, are -- as a rule -- not paid as well as other employees in jobs with comparable levels of responsibility or entrance requirements.

NEA strongly supports the cap on the percentage of wage income employees would have to pay for mandated premiums, and we believe it should not be set any higher than the proposed 3.9 percent.

For many years, NEA has steadfastly opposed the taxation of employee benefits. The Administration plan would exclude from taxation all elements of the guaranteed benefit package. And it would exclude, for 10 years, benefits beyond the basic plan that employees have at the time of adoption. These important provisions must be maintained. Employees have been able to gain these benefits over the years only by trading off wage increases, and they should not be disadvantaged by these changes. Moreover, Section 125 health care plans should be afforded similar protection during this 10-year period.

The Administration's plan proposes the imposition of the Medicare payroll tax on all public employees, a change we have opposed for a number of years. We remain deeply concerned that some state and local employees will be subject to this tax, and yet not be able to accrue sufficient quarters to qualify for Medicare by age 65. All public employees should be deemed qualified for Medicare coverage on reaching the age of 65, provided they have worked 40 quarters, regardless of whether or not such work was subject to the Social Security/Medicare tax.

Many of our members presently participate in health care organizations that are comparable to the regional alliances proposed in the Administration's health care plan. In order to minimize disruptions to beneficiaries and build on successful, existing structures, NEA believes that large public entities, such as trusts, voluntary employee benefit associations, and statewide plans, should be able to form separate alliances, if they are acting in the same manner as an alliance and enroll more than 50,000 members, including dependents.

Finally, given the historical link between collective bargaining and health care benefits, it is essential that the rights and benefits achieved through the collective bargaining process be protected in any health care initiative. We believe that the health care security of millions of families -- and ultimately of our nation -- has been made possible through the balance between employers and employees that is only possible in an environment of collective bargaining.

We recognize that this hearing is held early in a process that can be expected to take many months. The issue is complex, the stakes are high, and the interests of various affected individuals and institutions will often be in conflict. We pledge to assist this Subcommittee and this Congress in understanding the impact health care reform will have on public schools, our members, and the children we serve. And we offer our strongest support to an Administration and a Congress committed to see this monumental task through.

Thank you.

Mr. McDERMOTT. Thank you very much.

Mr. Kleczka will inquire.

Mr. KLECZKA. Thank you, Mr. Chairman.

Candice, in your written testimony, you indicate that public employers and ultimately public employees should not be asked to pay more for their health care than private employees and their workers. With the final package before us, we know that the public employers will be capped at 7.9, so that half is taken care of, but I don't recall any portion of any of the proposals that would treat public employees differently than private employees, that is, their 20 percent share of whatever plan they choose.

Ms. OWLEY. Certainly it was originally the 7.9 percent cap that was not on there for the public employees.

Mr. KLECZKA. Right.

Ms. OWLEY. Then second, the ability to form alliances, corporations of over 5,000, if they felt they could be efficient, were allowed to form separate alliances.

I might say that we would rather not have people over 5,000 forming a separate alliance, but in that case, we think there should be equity in terms of the public and private sector.

Mr. KLECZKA. So your bottom line is you don't buy the 5,000-plus alliances at all?

Ms. OWLEY. We would like to have everybody in the same system. We think that is the least cost shifting and the most efficient and so on.

Mr. KLECZKA. Would you give me a point of clarification, here? Are public employers now under the 5,000?

Ms. OWLEY. I don't believe so.

Mr. KLECZKA. I don't believe so, either.

Ms. OWLEY. No. Although I haven't seen it, there was some talk about some limited number of public employee groups being able to form some type of separate alliance, but I didn't see whether that ended up in the final form.

Mr. CHASE. There is nothing in the bill that would allow that to happen.

Mr. KLECZKA. OK. So I would assume you also agree, and your testimony, Mr. Chase, indicated that if we are going to do so for public employees, that is, 5,000 or more, then do so for—

Mr. CHASE. Yes. We think it should be a large enough group to be able to sustain the membership, minimum, and therefore propose a 50,000 member as far as public employees are concerned.

Mr. KLECZKA. I thought you misstated it. I was thinking you were saying 5,000.

Mr. CHASE. No, I didn't misstate it.

Mr. KLECZKA. You are saying 50,000.

Mr. CHASE. That is right. In actuality, if we were to have our druthers, it would be that all people would participate in the alliances and these separate corporate alliances would not be allowed.

Mr. KLECZKA. That is interesting. Thank you very much.

Mr. McDERMOTT. Mr. Levin will inquire.

Mr. LEVIN. Your testimony is welcome. We have, as you can hear, votes. Do, if you would, send us some further information on this issue.

The idea that public employee units and employee units of 5,000 or more should be interested is an interesting one. So if you would, we are all going to be working on this during the next months, provide us any additional information that you would like.

I am not sure there is complete comparability. I am not sure, but maybe there is. Clearly, the question needs to be looked at, so we will look forward to receiving further information.

Thank you.

Mr. McDERMOTT. I would like to ask one question of Mr. Hoffman, and that is the question about the retiree benefits. There is a fairly significant windfall to a lot of large companies as a result of the President's proposal. Would your union object if we captured some of that windfall to the companies and used it for financing other parts of the proposal?

Mr. HOFFMAN. When you refer to a windfall, I have a different view. First of all, the need is desperate to restore a level playing field, so what you refer to as a windfall, we refer to as restoring a level playing field.

Mr. McDERMOTT. A level playing field with whom?

Mr. HOFFMAN. With lots of different folks.

Mr. McDERMOTT. That is?

Mr. HOFFMAN. For green field employers here, for international competitors, for State and local governments, for parts suppliers, for Taft-Hartley plans, those that have been responsible to provide retiree health care coverage for their early retirees in the face of their opposition, competitors not providing the same. So to start with, I begin from a difference premise from that which you asked the question.

The second point that I would make is that as we examine this, if you start from a single-payer perspective, which is where we started with from 30 years and plus ago and where you have been and where we have been supportive of your leadership in this. Some of these cross-subsidies that exist when you come forth with a different approach are just taken care of under the fact that universal coverage is straight and across the board.

I don't hear anybody calling it a windfall to talk about the community rating. Those groups that were sicker are, all of a sudden, going to have a windfall. In fact, what we are doing is we are restoring a level playing field. We are saying that those people who are sicker aren't going to be penalized any longer for having to pay more. Those groups that are providing coverage for people who have early retirees aren't going to be penalized any longer vis-a-vis their competition.

In addition, I heard earlier in the hearing—I was being attentive, and I was hearing that these are people that go fishing. Gentlemen, with all due respect, I have seen so many tragedies, not people going fishing. These are people that are oftentimes involuntarily in retirement, either through a disability or their plant closed or they have no other choice. They are offered the opportunity to either retire on a rather meager pension or move hundreds of miles and leave their family behind. There are incredible problems out there, and I don't view it as a windfall.

Now having said that, let me say some other things about it, since you raised the issue, if I may.

I think we need to focus in on the numbers. I think when we look at the numbers that you are talking about, included in the numbers that I heard before are some of the numbers that go to the across-the-board subsidy for low-income folks and the across-the-board subsidy for community rating.

To the extent that there have been some studies done that show some of the payroll tax under FICA from payroll tax would no longer be there due to some, perhaps earlier retirement than otherwise would have occurred, or some subsidies were to cross that, we have been supportive of this 1-, 2-, 3-year payment to make sure that the trust funds are taken care of.

But I object completely to this idea of a windfall. I have bargained in Canada versus the United States, representing workers there in competition with workers here. I have bargained here and there. There is no question, there is no question that the retiree health care burden of many of the manufacturing companies in this country is an inordinate penalty that they are carrying under a responsibility that we helped encourage them to carry.

Mr. LEVIN. Will the gentleman yield?

Mr. McDERMOTT. Sure.

Mr. LEVIN. We have to leave, but I am very glad you asked that question. No, seriously, I am. I heard the reference by someone else to windfall, and I think this gets the debate off on a very wrong foot.

Mr. McDERMOTT. I would just say, I asked that question at the suggestion of the chairman because I think the question of subsidies is going to be a tough one for us to deal with. It is clear that the subsidy mechanism of single payer is that you put everything in the pot and everybody takes out what they need. Once you get into the business of trying to subsidize one group over another, you create all the questions and you raise all these problems which, I think, ultimately will be a part of this debate. This is obviously not the last hearing we will have on this.

The meeting stands adjourned.

[Whereupon, at 12:08 p.m., the hearing adjourned, to reconvene on Tuesday, November 2, 1993.]

[A submission for the record follows:]

**STATEMENT OF JOHN N. STURDIVANT
NATIONAL PRESIDENT, AMERICAN FEDERATION
OF GOVERNMENT EMPLOYEES AFL-CIO**

Mr. Chairman and members of the Committee: My name is John Sturdivant and I am the National President of the American Federation of Government Employees, AFL-CIO. On behalf of the more than 700,000 federal and District of Columbia employees our union represents, I thank you for the opportunity to testify. AFGE has been active for decades in the effort to reform our nation's health care system to one which resembles Canada's single payor format. It is therefore a pleasure to come before you today to engage in discussion over how to improve an already excellent blueprint for guaranteeing every American high-quality and affordable health insurance.

AFGE would like to congratulate President Clinton for keeping his promise to make national health care reform a top priority of his administration. The question of the day is no longer whether we need reform, but rather what is the best approach to reform. The President deserves credit not only for this, but also for keeping the principles of universal coverage and stringent cost containment at the heart of his proposals.

AFGE has been highly critical of the Federal Employees Health Benefits Program (FEHBP). Despite the fact that the approach to providing access embodied in President Clinton's plan appears to be modeled loosely on the FEHBP, we believe that it is structurally superior to FEHBP in many ways. In particular, it avoids risk segmentation by specifying a minimum standard benefit package, it avoids cost-shifting by providing universal coverage, and perhaps most important, it provides genuine cost containment through global budgeting and coordinated allocation of health care technology.

The most critical failing of FEHBP from the perspective of employees has been inadequate employer financing. In 1989, the Congressional Research Service (CRS) conducted a comprehensive analysis of FEHBP and found that on average, the federal government spent \$1,100 less annually per employee on health insurance coverage than the typical large private sector employer. Despite the fact that some large corporations have increased out-of-pocket costs for their employees in recent years, that gap has increased slightly in the last four years. The most glaring and shameful result of the federal government's inadequate contribution to health insurance benefits for its employees is that according to the OPM's Central Personnel Data File (CPDP), 18.6 percent of federal employees who are eligible to participate in FEHBP do not. Almost half of these federal employees do not have health insurance coverage from another source.

To put it plainly: In 1990, 160,000 full-time, year-around, permanent federal employees had no health insurance, and when surveyed by OPM as to why they did not participate in FEHBP, they replied that they could not afford it. In testimony last week, OPM Director Jim King indicated that the number of full-time federal employees without any health insurance coverage had grown to 300,000.

According to President Clinton's own numbers, 30 million of the 37 million Americans who have no health insurance are employed. The sad fact is that 7 percent of the federal government's own career workforce has no health insurance because they lack the means to pay for it. This fact represents the failure of both the FEHBP as well as the nation's health care delivery system, of which FEHBP is just a small part. So it is in this context that we question the President's goal to leave federal employees "no worse off" as a result of reform. The health insurance benefits provided to federal employees must be improved under reform, not only for those who cannot afford coverage currently, but also for those who need more comprehensive and more affordable coverage than they currently receive.

Once the principle is accepted that elimination of FEHBP in favor of participation in regional health alliances established as part of the Health Security Act should leave federal employees better off, the difficult task of specifying the formula for improving their benefit begins. The question becomes how to take a group of 9 million active federal employees, annuitants, and their dependents, who are currently enrolled in more than 300 different plans with various premiums and

benefits, and put them into a new system with at least 153 new plans (at 3 per state plus the District of Columbia) and make them better off?

The answer would be clear and simple if the standard benefits package were truly comprehensive and fully financed by employers or through the federal tax system. But the President has not chosen this road.

At a minimum, AFGE's goal is to make certain that federal employees pay no more than they do now, and to make certain that their benefits are at least equivalent to what they currently receive. To accomplish this, we must consider both premium contributions and benefit packages which are different from the minimums proposed in the President's bill.

To begin, we must arrive at a definition of what federal employees currently receive. It is not enough to make certain that the dollar value of the government's contribution does not decline; our goal for reform is that through cost controls, the elimination of cost-shifting, and reallocation of resources, each health care dollar will be able to purchase more. Thus we must define both the current cost of FEHBP, as well as the health benefit package which is available through the program.

There is no straightforward way to define the prevailing benefits or costs in FEHBP. Different plans have different benefits and premiums. The premiums charged in Blue Cross and Blue Shield's High Option have been skewed by the risk characteristics of enrollees so much that there is a nearly 250 percent variance between the actuarial value of the plan's benefits and its premiums. Some plans have the "best" benefits, some have the "best" price relative to benefits (but poor benefits), and some have the "best" price. The truth is there is no "best" plan in FEHBP. What then should be the standard measure, the standard against which we measure any new plan and call it a good deal for federal employees as a group?

Blue Cross Blue Shield Standard Option has the largest concentration of FEHBP enrollment, but it does not have the most comprehensive benefits. Worse, its benefits change from year to year. There is no strict floor on the benefits plans must provide to participate in FEHBP; OPM may require coverage for a category of treatment, but they do not make requirements about the rate or form of indemnity the insurer must provide. AFGE will not worry about the fact that there are some people enrolled in FEHBP who have very low-cost plans with minimal benefits: they will likely pay more as a result of reform, but they will also receive better benefits. But we are concerned with protecting the benefit levels of those in plans with very high benefits. The cost of the benefits included in these "high" option plans is reflected in the government's premium contribution to every plan in FEHBP, so they can not be considered as exceptions or outliers which do not affect the prices of other plans. The concentration of high risk individuals in particular plans also allows other plans to charge lower premiums than they could in a system free of risk segmentation. Thus both the premiums offered and the benefits charged in all plans which enroll federal employees must be considered in defining the current FEHBP benefit.

Dr. Judith Feder, who testified along with OPM Director Jim King before this committee last week, claimed that the actuarial value of the benefits in the President's standard package was roughly equivalent to the average set of benefits offered in FEHBP plans. The differences, she said, were in the types of services covered, with the President's plan placing relatively higher priority on preventive care for both adults and children. Representative Eleanor Holmes Norton (D-D.C.) questioned whether the actuarial value of hospitalization coverage was comparable to that of preventive care, and Dr. Feder implied that it was, but evaded the question by arguing that if federal enrollees chose "low-cost sharing" plans, i.e. HMOs, the problem became moot.

AFGE considers this a crucial issue which cannot be avoided: Federal employees should not be forced to concede complete coverage for hospitalization in order to gain eligibility for prepaid preventive care. And the price of having both should not consign one to the restrictions of an HMO. The current system, with all its flaws, provides a majority of participants with both 100 percent hospitalization, and a variety of preventive services for both children and adults, including dental care. Moreover, the majority of FEHBP participants receive these benefits through fee-for-service plans which they have chosen over other "lower cost-sharing" formats.

AFGE believes that the contention that comprehensive preventive service coverage represents a benefit with roughly equivalent actuarial value to the last 20 percent of hospitalization coverage is specious. We request that some attempt be made to validate this assertion with empirical data before federal employees are denied what we consider enormously valuable hospitalization coverage. Our own experience suggests that the data will refute this claim.

Federal employees want national health care reform, but we are firm in our belief that the advantages positive reform will bring, such as cost containment, universal coverage, rational allocation of resources, etc.; will allow the federal government to provide federal employees with superior benefits and lower overall costs than currently exist under the FEHBP. Indeed, Dr. Feder, speaking for the Administration at last week's hearing before this Committee, acknowledged that the government expects to spend less on federal employee health benefits as a result of reform. The rhetoric of the Administration as it promotes its plan is that it will lower health care costs for corporations that currently provide comprehensive benefits, making possible an end to the stagnation in wages that working people have suffered over the last 15 years as health care costs have spiraled. The federal government, as an employer, will also see its costs fall. But as the Health Security Act is written, any savings under the new system would apparently accrue to the government. AFGE wants to make certain that if real costs do decline, federal employees benefit from those savings.

Given the complexities in defining the "prevailing" FEHBP benefit, AFGE believes that federal employees should be provided the set of benefits in FEHBP's 1994 Blue Cross and Blue Shield standard option plan, with the government paying 90 percent of the premium for such benefits. The differences between these benefits, and those offered in the Health Security Act's standard package for the "high cost-sharing" option must be made available in a supplemental package. The government's total contribution would then be calculated on an additive basis, as the sum of 90 percent of the weighted average premium in a given standard "alliance" package, and 90 percent of a community-rated premium for a supplemental package which would bring federal employees' coverage up to the level of the 1994 Blue Cross and Blue Shield standard option. In areas where the benefits in the President's standard package are superior to those in the Blue Cross package, federal employees should receive the higher benefit.

The types of benefits which would be included in this supplemental package would be 100 percent inpatient hospital care with no limit on the number of days and no per admission deductible if the hospital were in a plan's network, and 100 percent for such care after a \$250 per admission deductible, if the hospital were outside the network. Fee schedule allowances for adult dental care and lower annual out-of-pocket maxima would also be included. There are other specific benefits and coverage levels included in the Blue Cross plan that vary from the proposed "standard" package which AFGE would be happy to provide to the Committee.

The final explicit safeguard which AFGE believes needs to be included in the legislation involves the impact of variations in premiums by locality. In the short run, we anticipate that there will be large differences in local alliance premiums based on the risk characteristics of local populations. Areas with large concentrations

of people who are elderly, poor, under-served, etc. are likely to have premiums which would result in federal employees' having to pay more than they currently do in FEHBP's national plans, despite the seeming improvement in the cost-sharing formula. Ten percent of a higher premium in, say, Washington, D.C., may be higher than 28 percent of the current FEHBP experience-rated premium which applies equally to federal employees throughout the nation. The principle of protecting federal workers so that none is worse off as a result of reform will require special coinsurance rates in these cases.

The benefits in the Blue Cross and Blue Shield plan, along with supplemental cost-sharing adjustments in areas with extraordinarily high local costs, would bring federal compensation closer to that offered by large private sector employers. The government/employer contribution would continue to be lower, both in percentage and nominal terms, but the benefits would be closer to parity. AFGE has made the argument repeatedly, in the context of salaries, health benefits, and retirement benefits, that compensation parity with non-federal employers is vital to the government's effort to recruit and retain highly qualified and highly motivated workers.

The reinventing government initiative, which AFGE has supported, is based on the belief that a workforce that is smaller, but more highly "valued" will succeed in regaining the public's trust and respect. Federal workers who receive better pay and benefits, more training opportunity, more responsibility, more control over their work will be motivated in a variety of ways to create a government that is more efficient and responsive to the people it serves. AFGE shares these goals with the Clinton administration, and we believe that improving federal employees' health care coverage at the same time that national health care reform is undertaken will go far in helping to accomplish them.

The Problems of the District of Columbia

AFGE represents over 55,000 residents of the District of Columbia, who work for both the federal and District governments. We are gravely concerned about the disadvantages we foresee for the City of Washington if health alliances are established on a state-by-state basis. The risk pool for Washington is similar to other large urban centers, and will include an extraordinarily high proportion of people who represent high health care risks: the poor, substance abusers, those exposed to violence, and previously uninsured people whose health status has suffered because they have not had regular access to preventive care. Washington, D.C. has the nation's highest per capita rate of both AIDS and HIV infection. It has the nation's highest infant mortality rate, and one of the highest homicide rates. Other urban areas with similar populations will benefit from inclusion in an alliance area which brings wealthier and healthier suburban residents together in a more diverse pool. But Washington does not have that advantage.

These issues are of particular concern to AFGE because federal and District of Columbia employees represent a significant majority of the insured population of Washington. We will feel the direct impact of the District's disadvantages.

There is no incentive in the President's bill for either Virginia or Maryland to include a high-cost urban area like Washington, D.C. in their state alliances, even though they would be permitted to do so. Although agreements will undoubtedly be made which will allow residents of the Washington suburbs to utilize the city's excellent health care facilities, the problem remains that Washington's residents will be disadvantaged relative to those in other urban areas, as well as those who work there but live in its suburbs.

Without some provision of subsidies to compensate for the District's disadvantages, all of the social and economic problems which make the Washington population high-risk to begin with will be exacerbated. Since individuals will enroll in plans based on where they reside as

opposed to where they work, District residents will be less attractive to employers because the premiums for their care will be higher than those of suburban residents. Unemployment and poverty in the District will increase. Firms will find it economical to locate in the suburbs rather than the city, and residents who can afford to will also be inclined to leave. The attendant decreases in tax revenues will also exacerbate the City's problems, causing continued funding problems for public schools and other public services.

Other urban areas which include more than one state will face similar difficulties, but the fact that the District is not a state makes it uniquely vulnerable, especially in terms of the restrictions in taxing authority it faces. AFGE believes that in order to avoid the devastating fallout which would result from implementation of the President's bill as it is written, Washington D.C. will need either direct subsidies for its population, or the surrounding states will need financial inducements to include Washington residents in their alliances.

Because of the high concentration of federal employees living in the District, the high premiums which would be charged in Washington if it remains isolated are of concern to all federal employees. The local boundaries drawn for the locality pay system, which reflect commuting patterns, stretch from Baltimore to Saint Mary's County in Maryland to Prince William County in Virginia. This "community" will be paid on the same basis, but is likely to face vastly different health insurance premiums, unlike in the current system. AFGE urges the committee to address the unique disadvantages federal employees living in Washington, D.C. face.

The Politics of Inclusion in Local Alliances

There is an awkward political problem regarding federal employees' health benefits under the Clinton plan: the so-called "standard benefits package" proposed for all Americans is inferior to that provided to Congress, the Executive Branch and members of the Federal Judiciary. If the plan is not good enough for us, why then is it good enough for everyone else? The political symbolism is difficult to ignore. But the problem is solved by acknowledging that the "standard" package represents only a minimum.

AFGE has never supported the idea of maintaining FEHBP as a separate, private program once national health care reform was enacted. On the contrary, we have always supported universal coverage and participation, including federal employees. In fact, we do not support the right of large employers to form their own "corporate alliances" outside the community-based alliance system because we think this allows them to be free-riders, taking advantage of the community's health care infrastructure -- medical education, hospitals, the benefits of subsidized medical and pharmaceutical research, etc.--without having to pay the community rated premiums which will reflect the costs of supporting this infrastructure.

AFGE has no particular affinity for the FEHBP system, and we believe that the Clinton plan holds the potential to be a vast improvement. But we do not want federal employees to suffer in order to maintain the pretense that the President's reform plan will mean everyone in America will have the same coverage. AFGE would likely have supported such a plan, but that is not what the President has proposed. Thus the standard benefits package must be seen as a minimum, or floor. It reflects the fiscal constraints on the federal government and the competitive restraints on some businesses. Ideally, everyone would have more comprehensive benefits than are specified in the floor, just as everyone would be paid more than the minimum wage. But a variety of political and economic factors have forced the President to be more modest in his benefits package than any of us might have preferred.

Federal employees currently receive health benefits which are superior to those in the standard package, and we are not prepared to receive

less under reform. We believe that guaranteeing the benefits set forth in the 1994 Blue Cross and Blue Shield FEHBP plan, with a government contribution to the premium set at 90 percent, is an appropriate solution. It would be a slight improvement over the status quo for the majority of federal employees.

Conclusion

AFGE supports President Clinton's prodigious effort to solve our nation's health care crisis in a way that preserves what is good and eliminates what is wrong. But we will not support the bill if it causes a reduction in health benefits or an increase in costs for federal employees. We consider the general approach to be fair, and are hopeful that if enacted, it will succeed in providing universal coverage, meaningful cost controls, and progressive financing. This concludes my testimony, and I will be happy to answer any questions you may have.

PRESIDENT'S HEALTH CARE REFORM PROPOSALS: ISSUES RELATING TO LONG-TERM CARE

TUESDAY, NOVEMBER 2, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman STARK. Good morning. This morning the Subcommittee on Health or at least its Chair will continue its series of hearings on the administration's health care reform bill by focusing on the long-term care provisions.

Less than a week ago, the President submitted the Health Security Act to the Congress, and I cosponsored that bill because it embraces the critical goals of providing universal coverage and access with verifiable cost controls. I might say parenthetically that having kissed the frog, it perhaps is still a frog.

The President's bill or plan acknowledges the need for long-term care reform, and the Health Security Act would establish a block grant to the various States to fund some home and community-based, long-term care services. It would establish Federal standards for private long-term care insurance and modify the tax treatment of such policies.

The plan would also make a number of relatively minor changes to the nursing home benefits under Medicaid, which are not within the jurisdiction of this committee.

While I applaud the President for his interest in long-term care, I have strong reservations with the approach that would establish a block grant to the States rather than provide an entitlement to individuals. We all know that block grants promise and have promised more than they can and have delivered in the past. If we intend to promise our constituents meaningful long-term care reform, we should do so and be willing to back it up.

If the President's numbers are any good, and he has gone to great length to have Mr. Magaziner tell us how accurate the numbers are, they should be willing to put their money where their mouths are and guarantee those benefits.

The purpose of an entitlement is to guarantee the citizens against the vicissitudes of government estimates and government financing, and we should do that if we are going to provide long-

term care. It should be an entitlement that the families can count on and not be worried about Republican gridlock in the Senate where it would only take 40 votes to block an issue.

Further, I am concerned that this bill would do nothing to address the very real fear of financial devastation that results from a long and costly stay in a nursing home. I would like to hear from witnesses today what their orders of priorities are. Is long-term care a principal priority or is some occasional home health care more the priority?

I don't think we will have enough money to pay for everything. During our hearing this morning, we will examine these issues in greater detail, and I look forward to the testimony of our witnesses which will be led off with the expert testimony from Josh Wiener, a senior fellow at the Brookings Institute. Mr. Wiener is an expert in long-term care issues and has testified before this subcommittee on a number of times in the past.

Since we last heard from you, Josh, you have served as an advisor to the White House Task Force on Long-Term Care Matters. You, I presume, have been to the top of the mountain and breathed the oxygen at 9,000 feet and returned to sea level and written your testimony, and so we welcome you back to the subcommittee.

As with all witnesses today, your written statements will be a part of the record of this hearing. In addition, I would like to ask you to limit your oral statements to 10 minutes or less. On the larger panels I might even ask you to limit it more than that. Then I will try and follow along with inquiries that will expand on your testimony.

The Chair will break from time to time for 5 or 10 minutes so I can watch the television and see what is happening to Senator Packwood. I will report back to you at that point. That is where all the television cameras are.

I am joined by the distinguished Congressman from the State of Washington, Mr. McDermott. We will proceed.

Jim, did you have a statement this morning?

Mr. McDERMOTT. No.

Chairman STARK. Josh, why don't you proceed to enlighten us in any manner you are comfortable.

STATEMENT OF JOSHUA M. WIENER, PH.D., SENIOR FELLOW, THE BROOKINGS INSTITUTION

Mr. WIENER. Thank you, Mr. Chairman. It is a pleasure to be here today. The United States is now engaged in an historic debate over how, not if, our health care system should be overhauled. While this debate is largely about acute care, it should also be about long-term care.

Americans suffer chronic conditions that require long-term care either at home or in an institution, in addition to acute illnesses requiring care in hospitals and by physicians. To begin to address these problems, the Clinton administration is proposing major new long-term care initiatives. While not promising to solve the problems of long-term care, they are promising to make a major start.

In my testimony today, I want to make four major points.

First, long-term care should be part of the health care reform legislation passed by Congress next year. I am forced to start with

this point because most of the alternatives to the President's proposals, bills by Senator Chafee, Senator Gramm, and Representatives Cooper and Grandy do not include major long-term care reform proposals.

The reason long-term care should be part of health care reform really amounts to four major points. First, and foremost, the current long-term care system is broken and needs to be fixed. The system has a strong institutional bias, a strong welfare dependence, and catastrophic out-of-pocket costs are routine in long-term care.

Second, the lesson of the Medicare Catastrophic Coverage Act is that the elderly care more about obtaining long-term care benefits than they do richer acute benefits, with the exception of prescription drugs.

Third, excluding long-term care services from the global budget creates strong incentives to substitute nursing home and home care services for acute care services or, less benignly, to reclassify acute care services as long-term care. Either way, long-term care could become a huge escape hatch from the global budgets. Moreover, there will be very strong pressure to provide additional long-term care services.

Fourth and finally, public opinion polls suggest that there is stronger political support for overall health care reform when long-term care is included than when it is excluded. It is a new benefit for virtually everyone.

The second major point I would like to make is that the limits of the private long-term care insurance market means that expansion of public programs is an essential component of long-term care reform. The harsh reality is that currently only about 4 to 5 percent of the elderly and a negligible proportion of the nonelderly have any form of private long-term care insurance.

One of the major problems is affordability. Most studies, including several done by ourselves at the Brookings Institution, find that only 10 to 20 percent of the elderly can afford private long-term care insurance. While higher percentages of the nonelderly can afford private long-term care insurance, it is a very difficult sell.

Moreover, private long-term care insurance, as is on the market today, has several problems. Most policies do not have an inflation adjustment; most do not have nonforfeiture benefits; and most have limited home care.

Thus, if we want to fix long-term care, we are forced to address our public programs, and here we have a basic choice. We can stay with means-tested programs, Medicaid primarily as the primary mechanism of financing long-term care, or we can finance more of nursing home and home care and other services through nonmeans tested, social insurance programs.

Fiscal realities require that the system rely on a mixture of public and private initiatives and the President's proposal does that. What is new, and from my perspective welcome, is the willingness to build on public programs. Unlike the last 12 years, President Clinton has not rejected out of hand new government initiatives and has not placed all of our hopes on reform on a small private insurance market.

The third point I would like to make is that given limited resources, a fundamental choice must be made about how much additional money to put into nursing home care and other institutional services and how much to put into home and community-based care.

As the chairman indicated, the case for nursing home care is that nursing home care, not home care, is the primary cause of catastrophic out-of-pocket costs for long-term care for the elderly. The case for home care is that the current financing and delivery system is very, very strongly tilted toward nursing home care already.

In 1993 we estimate that only about 36 percent of government long-term care expenditures for the elderly will be for home care, and most of that will be for the Medicare home health benefit, which many would argue is not long-term care at all. Moreover, home care is the kind of service that people say they want.

Clearly, the administration has chosen to focus on home care initiatives to try to create a more balanced delivery system. There is relatively little in the President's proposal on the nursing home side. While I wish that additional nursing home coverage was possible, given limited resources, I believe that the administration has made the right decision. My fourth and final point is that the President's proposal contains very strong mechanisms to control costs. In my view, the traditional congressional worries about runaway long-term care expenditures are not warranted with this program.

As we look over the history of long-term care debate over the last several years, major long-term care initiatives have failed to be enacted partly because of the absolute level of costs involved, but also because of the uncertainty about what the costs will actually be.

Since most persons who would qualify for either public or private long-term care programs do not currently receive any formal services, the potential for substantial utilization increases and expenditure increases are large. Although most of the policy discussions about long-term care reform over the last few years have been within the context of open-ended entitlement programs, such as Medicare and Medicaid, an explicit cap as suggested by the President would come close to guaranteeing that spending did not exceed a set amount.

Moreover, open-ended entitlements are under attack throughout Congress and acute care is budgeted in the President's proposal. Opponents of capping the program worry that spending will not increase with need and inflation, and as the chairman noted, our experience with block grants from the 1980s has not been a happy one. These concerns are serious ones, but policymakers are so frightened by the expenditure uncertainties that it is doubtful that major long-term care initiatives can be passed without some fail-safe mechanism to limit overall financial risk.

If Federal expenditures are capped, the crucial issue is whether it is possible to provide a very flexible set of services which the disabled, both young and old, need, and still retain a legal entitlement. The basic dilemma is that the more flexible the set of services provided, the more difficult it is to keep expenditures within a set amount. The administration has chosen to maximize flexibil-

ity of services and does not include a legal entitlement. I reluctantly agree.

Let me conclude by saying that unlike most health care reform proposals, President Clinton's health care plan does include major initiatives for long-term care. The President recognizes the inadequacies of the current system and proposes to start rectifying them. While his proposals are good ones, they are not the total solution to the problems of long-term care. They are, however, probably the most that can be expected within the current political environment.

The President's proposal represents an excellent beginning in the long march to reform long-term care financing and delivery. Difficult trade-offs exist here as well as in the rest of the President's health care plan, but the plan deserves the support of this committee and of Congress.

Thank you.

[The prepared statement follows:]

**TESTIMONY OF JOSHUA M. WIENER AND LAUREL HIXON ILLSTON
THE BROOKINGS INSTITUTION**

The United States is now engaged in an historic debate over how, not if, our health care system should be overhauled. President Clinton's call for reform has focused national attention on the problems and possible cures for uncontrolled health care costs and lack of adequate insurance. While this debate is largely about acute care, it should also be about long-term care. Americans suffer chronic conditions that require long-term care either at home or in nursing homes as well as acute illnesses requiring care in hospitals and by physicians.

To begin to address these problems, the Clinton Administration is proposing major new long-term care initiatives. The President's plan includes a major new home care program for the severely disabled of all ages and all income groups, modest liberalization of the financial eligibility rules for the Medicaid nursing home benefit, inclusion of some nursing home and home care in the acute care benefit package for the nonelderly, favorable tax clarification and tougher regulation of private long-term care insurance, and tax credits for the long-term care expenses of the nonelderly disabled who work. This testimony evaluates the proposed plan against several issues that must be addressed in designing a reform strategy.

Place of Long-Term Care on the Health Care Reform Agenda

Changes in the financing and delivery of long-term care reform are clearly part of the Administration's health reform effort and have been since the beginning. While the Administration is not promising to solve the problems of long-term care, as they are the problems of the uninsured and exploding acute care costs, President Clinton is firmly committed to making a major start at reform. In contrast, the proposals sponsored by Senator Chafee, Senator Gramm, Representatives Cooper and Grandy, and the House Republican leadership do not propose major reforms of long-term care financing and delivery.

While an honest appraisal is that long-term care reform is not integral to the inner logic of managed competition with global budgets, there are at least four reasons why it should be part of health care reform. First, the current long-term care system is broken and needs to be fixed. Routine catastrophic out-of-pocket costs, a lack of home care, and welfare dependence are just a few of the problems that plague the current system. Indeed, no other part of the health care system generates as much passionate dissatisfaction as does long-term care.

Second, the minimum benefit package for acute care for the non-elderly is substantially more generous than existing Medicare benefits. The political difficulty is that, with the exception of prescription drugs, most elderly already have most of this expanded coverage through their supplemental private insurance. For them, expanded acute care coverage will not be a new benefit, but would entail substantial new government expenditures. It would be a better policy, and more politically popular, to put that new money into long-term care services.

Third, excluding long-term care services from the global budget creates strong incentives either to substitute nursing home and home care for hospital services, or, less benignly, to reclassify acute care services as long-term care. In either case, the long-term care sector could become a huge escape hatch from the global budget and will inevitably mean greater pressure to provide more long-term care services to more people.

Finally, inclusion of long-term care garners substantial additional popular support for general health care reform. Although public opinion polls, especially those sponsored by interest groups, must be viewed cautiously, recent surveys sponsored by Consumers Union and by the American Association of Retired Persons find much

These opinions are those of the authors and do not necessarily represent the views of other staff members, officers or trustees of The Brookings Institution.

greater enthusiasm for health reform if long-term care benefits are included.¹ Contrary to conventional expectations, support for long-term care does not seem to vary greatly by age.

"Proper" Balance on Public and Private Roles

While the debate over long-term care reform has many facets, it is primarily an argument over the relative merits of private versus public sector approaches. Differences over how much emphasis to put on each sector partly depends on values that cannot be directly proved or disproved. Some believe that the primary responsibility for care of the elderly and disabled belongs with individuals and their families, and that government should act only as a payer of last resort for those unable to provide for themselves. The opposite view is that the government should take the lead in ensuring comprehensive care for all disabled people, regardless of financial need, by providing comprehensive, compulsory social insurance. In this view, there is little or no role for the private sector. Between these polar positions, many combinations of public and private responsibility are possible, and most people would probably opt for some middle ground.

The choice of emphasis between public and private programs depends not just on political ideology, but also on whether private and public initiatives are affordable, whom they would benefit, and whether they can reduce catastrophic costs and realign the delivery system. For example, if it were demonstrably possible to market private long-term care insurance that would protect a large majority of the population from financial hardship and reduce dependence on Medicaid, then many people would see less of a need for new government programs. Conversely, if private insurance were not to prove widely affordable or to face other barriers that prevent people from voluntarily purchasing policies, then the case for an expanded public role is made stronger.

The hard reality is that only about 4-5 percent of the elderly and only a negligible percentage of the nonelderly currently have any kind of private long-term care insurance. Private insurance faces numerous barriers to becoming a significant force in the financing of long-term care. Most important is the fact that private long-term care insurance sold to the elderly is quite expensive; high quality policies cost as much as \$2,500 at age 67. As a result, numerous studies conclude that only between 10 and 20 percent of the current elderly can afford private long-term care insurance.² Other studies have found a higher percentage of the elderly who can afford private insurance, but they have done so only by assuming purchase of policies with limited coverage, by assuming that the elderly would use their assets as well as income to

¹ Gallup Survey for the Consumers Union, Executive Summary, March 26 - April 9, 1993; and ICR Survey Research Group poll for the American Association of Retired Persons, Executive Summary, April 21 - 27, 1993.

² Alice M. Rivlin and Joshua M. Wiener, Caring for the Disabled Elderly: Who Will Pay?, (Washington, D.C.: The Brookings Institution, 1988); Robert Friedland, Facing the Costs of Long-Term Care (Washington, D.C.: Employee Benefit Research Institute, 1990); Sheila R. Zedlewski and others, The Needs of the Elderly in the 21st Century (Washington, D.C.: Urban Institute Press, 1990); and, William H. Crown, John Capitan, and Walter N. Leutz, "Economic Rationality, the Affordability of Private Long-Term Care Insurance, and the Role for Public Policy," Gerontologist, Vol. 32 (August 1992), pp. 478-485.

pay the premiums, or by excluding a large percentage of the elderly from the pool of people considered to be interested in purchasing insurance.³

The story changes substantially if businesses could be convinced to offer private long-term care insurance to their active employees and if workers were willing to buy the product. However, selling properly structured policies to the non-elderly in large numbers will be extremely difficult. First, most people are either unaware of or deny their risk of needing long-term care. Research suggests that persons who live to age 65 face a roughly 40 percent chance of spending some time in a nursing home before they die and more than a one-in-six chance of spending more than a year in one.⁴ Second, misinformation abounds. Many people think that Medicare or Medicare supplemental policies ("Medigap") cover long-term care when they do not.⁵ Finally, younger adults have a number of competing demands on their disposable income (e.g. college education for children) which they consider a higher priority than the purchase of long-term care insurance.

Even if policies were more affordable, there is some question as to the quality of these products. Over the past several years, the content of long-term care insurance policies has changed dramatically, mostly for the better. Despite these advances, many policies still lack consumer protection features such as inflation protection, nonforfeiture benefits for lapsed policies, clearly defined benefit triggers, and adequate home care coverage. Correcting each of these deficiencies would add to the cost of the policy, making it less affordable.

Given the limitations of private insurance, public programs are likely to remain. The key question then becomes what do we want our public programs to look like. Although they can be combined in a variety of ways, there are two broad strategies. One approach would retain a means-tested welfare program--Medicaid--as the principal government program to finance long-term care, but would expand home care and liberalize the financial eligibility criteria so that the level of impoverishment required would not be so onerous. The other approach would create new social insurance programs for long-term care, where benefits would be provided without regard to the financial status of persons in need of services.

The Administration's policy preference is to move in the direction of social insurance. However, fiscal realities make a mixed public-private system inevitable and the President's proposal includes elements of social insurance, private insurance, and Medicaid reform. Nonetheless, a large shift in perspective has occurred. Unlike the Reagan and Bush Administrations, the Clinton Administration does not dismiss out-of-hand deliberate expansion of public programs and does not pin all of its hopes for reform on private long-term care insurance.

³ Marc A. Cohen, Nanda Kumar, Thomas McGuire, and Stanley S. Wallack, "Financing Long-Term Care: A Practical Mix of Public and Private," Journal of Health Politics, Policy and Law, vol. 17 (Fall 1992), pp. 403-424; Marc A. Cohen and others, "The Financial Capacity of the Elderly to Insure for Long-Term Care," Gerontologist, Vol. 27 (August 1987), pp. 494-502; and Ronald D. Hagen, "Testimony on Long-Term Care Insurance," in U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, Hearing to Investigate Alleged Abuses in the Marketing and Sale of Long-Term Health Care Insurance for the Elderly, Committee Serial 101-146, 101:2 (May 2, 1990), pp. 180-207.

⁴ Christopher Murtaugh, Peter Kemper, and Brenda Spillman, "The Risk of Nursing Home use in Later Life," Medical Care, Vol. 18 (October 1990), pp. 952-962.

⁵ Daniel Yankelovich Group, Inc., Long-Term Care in America: Public Attitudes and Possible Solutions, report prepared for the American Association of Retired Persons, (Washington, D.C., AARP, 1990).

Institutional vs. Noninstitutional Services

Given limited resources for new initiatives, a fundamental policy question is how much new money to devote to institutional services as opposed to home and community-based services. The case for allocating new resources to nursing homes rests on the fact that they are a primary cause of catastrophic health care expenses; limited data suggests that large out-of-pocket expenditures for home care services are much less common.⁶ Moreover, at least for the elderly population, few academic experts believe that significant reductions in nursing home use would be likely to result from the expansion of home care.⁷ With the aging population, the nation will inevitably need more nursing home beds in the future.

Notwithstanding these concerns, it is virtually certain that the major focus of new policy initiatives will be on expanding home and community-based services. Policymakers are reluctant to spend much more on nursing home care until a more balanced delivery system has been developed. In 1993, only about 36 percent of government long-term care expenditures for the elderly were for home care, and most of that was for Medicare home health, which is largely post-acute rather than long-term care. Moreover, home care is what persons with disabilities want. Indeed, nonelderly disabled advocates (such as ADAPT) want to radically reduce what is spent on institutional services. Home care is also politically popular. In a 1992-93 public opinion poll for HealthRight, over 80 percent of respondents favored a new federal home care program.

In this area, the President's plan is a dramatic initiative to tilt the service delivery system in the direction of home care rather than nursing home care. When the program is fully implemented, public expenditures for home care will be over \$20 billion more than they would have been otherwise. Under this plan, the severely disabled will have major new access to services designed to meet their needs in the community.

Protection Against Catastrophic Costs

At present, the principles of the long-term care financing system contrast radically with those of the Medicare program. Virtually no one argues that the sick or even terminally ill should use all of their income and deplete their assets to pay for their hospital or physician care, yet doing so is routine in long-term care.

With the average cost of a year in a nursing home exceeding \$30,000 a year and very little public or private insurance coverage available, it not surprising that users of long-term care services incur very high out-of-pocket costs. In one recent study of the severely disabled elderly, persons who used nursing home care spent an average of 90 percent of their income for medical care.⁸

⁶ Korbin Liu, Kenneth G. Manton, and Barbara Marzetta Liu, "Home Care Expenses for the Disabled Elderly," Health Care Financing Review, Vol. 7, No. 2, (Winter 1985), pp. 51-58.

⁷ Joshua M. Wiener and Raymond J. Hanley, "Caring for the Disabled Elderly: There's No Place Like Home," in Improving Health Policy and Management: Nine Critical Research Issues for the 1990s, Stephen M. Shortell and Uwe E. Reinhardt, eds., (Ann Arbor: Health Administration Press, 1992), pp. 75-110.

⁸ Coughlin and others, "Severely Disabled Elderly Persons With Financially Catastrophic Health Care Expenses," p. 402.

Protecting the elderly against the financial burdens of long-term care means, in part, preventing the elderly from impoverishing themselves simply because they need nursing home or extensive home care. Currently, in many instances, the middle-class elderly spend all of their income for long-term care and then resort to their life savings when income alone does not cover the costs. Some of these people will completely deplete their savings and assets and be forced to rely on Medicaid to pay for their care. Even when nursing home and home care patients do not end up on Medicaid, long-term care still imposes a substantial financial burden that can be financially crippling.

While the President's plan improves protection against catastrophic out-of-pocket costs by modestly increasing the income and assets that Medicaid nursing home patients may keep and by providing extensive coverage of home care, the proposal is relatively weak in this area. This is because, as noted above, nursing home rather than home care is the prime cause of catastrophic out-of-pocket costs for long-term care. Adding nursing home coverage to the proposed expansion of home care would be desirable, but would add to the cost of the proposal.

Prevention of Dependence on Welfare

Another aspect of protecting people against the financial burdens of long-term care is keeping people who have been financially independent from having to depend on welfare--Medicaid--with its inferior access, stigma and perhaps inadequate quality of care. While most current nursing home residents are eligible for Medicaid, an unknown but probably substantial portion were not Medicaid eligible in the community or become eligible soon before admission. This group probably has low levels of assets but too much income to qualify for Medicaid in the community. However, the high cost of nursing home care make them eligible for Medicaid immediately upon entry to the nursing home.⁹

Ironically, while the President's proposal to increase the amount of income and assets that Medicaid nursing home patients can keep will improve protection against catastrophic out-of-pocket costs, it will increase the extent of welfare dependence among the nursing home population. In the home care area, however, most people will obtain coverage through the nonmeans-tested program and disability will be treated more as a normal risk of life, rather than a personal failure deserving of charity.

Balance of Federal and State Roles

Currently, the lion's share of publicly-funded long-term care is available through the Medicaid program. Although both federal and state governments are involved in the financing and policymaking, operational responsibility for managing the system is primarily the province of the states. States regulate the supply and quality of care, set reimbursement rates, write contracts with providers, process claims and coordinate the care of clients.

Previous social insurance proposals--including those of Senator George Mitchell, Senator Edward Kennedy, Congressman Henry Waxman, Congressman Pete Stark, and the Pepper Commission--prescribed very limited roles for the states. Although these earlier proposals depend on states for administration, policymaking and financing was to be federally controlled. While such an approach is a natural extension of the current Medicare and Social Security programs in which states have no role, it would be a grievous mistake in long-term care for a number of reasons.

⁹ Brian O. Burwell, E. Kathleen Adams, and Mark R. Meiners, "Spend-Down of Assets Before Medicaid Eligibility Among Elderly Nursing Home Recipients in Michigan," Medical Care, vol. 28 (April 1990), pp. 349-62.

First, failure to include the states as financial partners will convert any public insurance program into a state project for maximizing federal funds. That is, states will have a strong incentive to make sure that as many people receive as many services as possible because it brings in "free" federal money. States will also have little reason to control the supply of services. Requiring states to incur some of the costs and the risks of a public insurance program will necessitate giving them a role in policymaking. Although this raises the specter of the interstate variation that plagues the Medicaid program, and will undoubtedly complicate the decision-making process, the alternative is a prescription for financial problems at the federal level.

Second, because states have the substantive experience in developing long-term care delivery systems, a configuration where states have a strong role would capitalize on the creativity and expertise available there. A state-administered approach would also allow any new program to be implemented more quickly.

Third, long-term care is a local issue; the planning and delivery of services is greatly influenced by the local circumstances and particular norms of the area. For example, a thoughtfully-designed care plan in rural Alabama would not make sense in New York City because the resources (both financial and other) vary so greatly between these locations. The long-term care systems in Europe are striking for their radical decentralization down to the local level, far below anything being contemplated in the United States.

The Administration's plan clearly gives States the lead role in designing and administering the new home care program. Given the large infusion of federal funds, many in Congress will be uncomfortable giving States as much flexibility and authority as envisioned in the President's plan. Nonetheless, the lessons from other countries as well as the U.S. strongly point in the direction of local control.

Integration of the Elderly and Nonelderly Disabled

Previous policy debates about long-term care reform have focused solely on the elderly, virtually ignoring the non-elderly disabled. Those days are past. In the current debate, the nonelderly disabled have a seat at the policy table and their views count.

This new-found political strength is due to two factors. First, exhilarated by their success with the Americans with Disabilities Act, the nonelderly have simply pushed themselves into the debate. Second, in order to counter arguments about generational equity, elderly advocacy groups are promoting long-term care as a problem that affects all age groups, not just the elderly.

As a result of elderly and nonelderly advocacy groups joining together, there is substantial policy interest in a single program that would include all disabled persons--the frail elderly, persons with Alzheimer's Disease, the mentally retarded, the non-elderly physically disabled, and the mentally ill. While these groups have locked arms out of fear of being left out of a new program, there are reasons to question whether all groups will be well served by this single-program strategy. Although there are similarities across disability groups and all need services, there are also substantial differences. These differences exist in the areas of eligibility criteria, breadth of services needed, and desire to control and direct the services.

All programs need criteria to establish who is eligible for services and who is not. The difficulty is that measures--specifically, activities of daily living (i.e., eating, bathing, dressing, toileting, and transferring)--that work pretty well for the elderly in separating the severely impaired from the mildly disabled do a relatively poor job for the nonelderly disabled. In particular, they do not "capture" many of the persons that Medicaid is already servicing. This is especially true for the mentally retarded/developmentally disabled, many of whom have severe limitations in the

instrumental activities of daily living (such as managing money and housekeeping) but not the activities of daily living. Expanding eligibility to include the instrumental activities of daily living would grant eligibility to very large numbers of elderly, making the program prohibitively expensive. Keeping the criteria narrow excludes many persons that intuitively should be covered.

Relatedly, there is a difference between the elderly and non-elderly in the breadth of services needed. Most programs for the elderly provide a relatively narrow range of services, primarily personal care and homemaker services. Conversely, the range of services used by the nonelderly disabled is far broader. For example, the mentally retarded use everything from personal care to vocational training.

This much broader range of services partly reflects broader needs, but it also reflects different expectations. For most people, it is acceptable for a disabled elder to live with her daughter and to spend most of her time at home. This is not considered acceptable by the under 65 disabled population, who want to live independently and to fully participate in what the world has to offer. For them the notion of "home" care threatens to imprison them within the narrow physical structure where they sleep.

Finally, the elderly and nonelderly disabled have different views concerning who hires and directs the services. The overwhelming majority of home care services for the elderly are provided through an agency, which is responsible for the performance of its employees. In contrast, the nonelderly disabled are very distrustful of home care agencies. At least in the view of advocates, the nonelderly physically disabled want to be able to hire their own home care workers and decide when, where, and what they will do. For persons familiar with elderly programs, this approach raises troublesome issues of quality assurance. It also raises administrative questions of who is responsible for paying Social Security, unemployment compensation, and (after health care reform) health insurance.

On this issue, the Administration has been unambiguous. The proposal covers disabled persons of all ages and without regard to previous financial contributions to the Social Security or Medicare systems. In my view, however, it does not make complete sense to have all disabled persons in one single program. In particular, I would finance services for the mentally retarded/developmentally disabled through a separate program, which would combine their new home care expenditures with existing Medicaid expenditures for intermediate care facilities for the mentally retarded (ICF/MRs) and community based services. There are real possibilities for reallocation of resources from institutional to noninstitutional services for this population that may not exist for other segments of the disabled population.

Integration of Acute & Long-Term Care

Over the last decade, there has been increasing recognition of the lack of coordination between acute and long-term care. Under the present configuration, the federal Medicare program is the dominant player in acute care for the elderly, while long-term care services are primarily organized and funded by state-run Medicaid programs or out-of-pocket. A few efforts, including the social health maintenance organizations or S/HMOs, San Francisco's On Lok and its national replications sites, and the members of the National Chronic Care Consortium, attempt to integrate these two types of care. The premise behind bringing the elderly and disabled into a program where there is better coordination of service delivery and integrated financing of care is that the beneficiaries would receive higher quality, more cost effective acute and long-term care.

These models strive to avoid both the functional decline that can result from unmet needs and the unnecessary costs associated with overmet needs. At least in theory, this would produce savings on the acute care side because lower-cost outpatient services could be substituted for more costly inpatient services when

appropriate.¹⁰ These acute care savings, in turn, could be used to fund more comprehensive long-term care benefits. Brief institutional placements could also be used for caregiver respite or patient monitoring so that patients could ultimately be kept in their homes longer.¹¹ Moreover, the capitated, risk-based financing structure of these models creates strong incentives to provide appropriate services at the lowest possible cost.

While the idea of acute/long-term care integration seems sound, there are not a lot of successful models from which to learn. In addition, with the prospect of being able to enroll 33-37 million uninsured and many more people who will be steered toward them by cost considerations, it is not at all clear that HMOs will be interested in working with the disabled elderly and non-elderly. After all, the elderly and disabled are expensive to treat and have needs that HMOs are not used to addressing.

By consciously deciding not to include most long-term care services in the basic benefit package, and by relying on the states to administer the new program, the Administration's proposal will make integration of acute and long-term care service difficult. Nonetheless, this is the right decision because acute care insurers and providers know little about long-term care. Moreover, the "medical model" is inappropriate for much of long-term care. The Administration leaves open the possibility of integration without prescribing how it will be done.

Cost Containment

To date, efforts to enact public insurance programs for long-term care have failed largely because of fears about costs.¹² Policymakers have two concerns. The first is over the absolute level of expenditures required. All public insurance programs will require substantial additional public expenditures. The second concern is that however honest the estimates of program costs may be, they will prove to be too low. No policymaker wants to wake up one day and discover that the actual costs of the program are twice the original estimate.

Although most of the policy discussions about long-term care reforms have been within the context of open-ended entitlement programs like Medicare and Medicaid, an explicit cap on new public long-term care expenditures would come close to guaranteeing that spending did not exceed a set amount. In fact, open-ended entitlements are under attack in Congress and acute care is "budgeted" under the Clinton plan. Although an approach embodying universal access operating within a fixed budget is common to health programs in Europe and Canada, Americans have little experience with this strategy.

Opponents fear that once capped, expenditures will not rise with inflation, population, experience, or need. The fact is that fixed budget programs lack the automatic increases of entitlement programs. Supporters of this approach hope that since services would be provided to persons of all financial means, an effective political constituency would be created to lobby for funding increases. It would also help protect funding levels if financing for the program came primarily from a

¹⁰ Marie-Louise Ansak, "The On Lok model: Consolidating care and financing," Generations, Vol. 14, No. 2, (Spring 1990).

¹¹ Merwyn R. Greenlick, Lucy Nonnenkamp, Leonard Gruenberg, Walter Leutz, and Sara Lamb, "The S/HMO Demonstration: Policy Implications for Long Term Care in HMOs," Pride Institute Journal of Long Term Home Health Care, pp. 15-24.

¹² Joshua M. Wiener and Raymond J. Hanley, "Long-Term Care and Social Insurance: Issues and Prospects," Social Insurance Issues for the Nineties, Paul N. Van De Water, editor, (Dubuque, IA: Kendall/Hunt Publishing Company, 1992, pp.101-119.)

dedicated revenue source (such as a payroll tax). These reservations about capped programs are serious ones, but policymakers are so frightened by the expenditure uncertainties that it is doubtful whether major long-term care expansions can be passed without a fail-safe mechanism to limit overall financial risk.

If federal expenditures under the new program are to be capped, the crucial issue is whether it is possible to provide a flexible set of services and still retain an "entitlement" to services. An "entitlement" implies a legal obligation on the part of government to provide services to individuals who meet established criteria regardless of the budget impact on the government. The basic dilemma is that the more flexible the set of services provided, the more difficult it is to provide services on an entitlement basis and still keep expenditures within the appropriated amount. The broader the range of available services, the more likely persons will use them, raising overall expenditures.¹³

President Clinton's proposal for a major new home care program includes very strong mechanisms for cost containment. In addition to case management and cost sharing, the plan caps total federal expenditures under the program. Moreover, the plan does not include a legal entitlement to a defined set of services, allowing instead states to provide a wide range of services, tailoring each individual's service package to their needs. While I believe that capping expenditures and not including an entitlement are the right decisions, such decisions create political problems because it becomes difficult to describe what benefits people will actually receive.

Adequate Financing

Making sure there is enough money to fund the long-term care program (as well as the rest of the plan) is critical to its long-run stability and to avoid adding to the federal deficit. Nothing could be worse for health reform than to underestimate the costs and to underfund the program. In general, for the long-term care program, the Administration has used the best available data, has assumed a generous level of service per user and a high level of participation among the eligible population. While nobody can know for sure what a home care program for the severely disabled will cost, the Administration's estimates are an honest effort to calculate the costs of serving the population. Again, because expenditures are capped, they cannot exceed the level that is budgeted.

There are, however, two technical issues that make cost estimates for long-term care different from for acute care. First, because of the rapidly growing population age 75 and older, which is the primary users of long-term care, the population increase in the disabled population is likely to be faster than general population growth. This is especially true over the longer-run as the baby boom generation ages and starts to need long-term care services. Second, most of long-term care is hands-on, personal services for which there are not great prospects for productivity or efficiency improvements. Over the long-run, therefore, if we want people to work in this sector, they must receive wage increases at least equal to what is being achieved in the rest of the economy. This implies that long-term care wages and prices will need to increase faster than general inflation. The Administration's cost estimates deal fairly well with the first issue, but not the second. As I understand it, their cost estimates assume that home care prices can be kept to general inflation.

Although the President's plan does not specifically link particular budget cuts or revenues to specific initiatives, the long-term care component of the President's plan appears to be financed by Medicare and Medicaid savings and by the cigarette tax.

¹³ Some disability advocates argue that per person costs can be reduced through the use of a flexible set of services. This is based on the presumption that given a choice, people will choose only the minimum level of the services they actually need rather than choosing a larger amount of a service that does not quite meet their need.

Concerns have been raised by some as to whether the Medicare and Medicaid savings are too ambitious, at least over time in which they are proposed to take place, and cigarette tax revenue is likely to decrease rather than increase over time. Thus, it seems likely that additional sources of revenue will be needed to fund long-term care over the long run.

Conclusion

Unlike most competing proposals, President Clinton's health care plan includes major initiatives for long-term care reform. The President explicitly recognizes the inadequacies of the current system and attempts to rectify them. For this, he and his administration deserve enormous credit. While his proposals for long-term care are good ones, they are not a total solution to the problems of long-term care. They are, however, probably as much as can be done in the current political environment.

There are several strengths in the President's proposal. The plan recognizes the limitations of private insurance and contains a mix of public and private initiatives. The reality is that the private sector, by itself, is unlikely to ever play a truly major role in financing long-term care. If we are serious about reform, then changes in public sector programs are needed.

In that regard, coverage of home care for the severely disabled on a nonmeans-tested basis will go a long way to treating disability as a normal risk of life rather than the failure of the individual deserving of public charity through welfare. Broad coverage of home care will also go a long way to create a more balanced delivery system, giving clients more options than just nursing home and other forms of institutional care. Moreover, by capping expenditures and by not including a legal entitlement to services, the new home care program contains the strongest possible cost containment and gives states the needed flexibility to design services that make the most sense for individuals.

The limitations in the plan are mostly those dictated by fiscal realities. Most importantly, lack of broad coverage for nursing home care leaves unaddressed a major risk of catastrophic out-of-pocket costs for the elderly. In addition, while the expenditure cap and lack of entitlement for the home care program will successfully control expenditures, they also deny the program a guarantee that expenditures will increase over time with inflation and growth in the disabled population. The Administration's plan indexes spending to these factors, but without a legal entitlement, expenditure levels will remain vulnerable.

The President's proposal represents an excellent effort to move the long-term care system toward reform. Difficult tradeoffs exist here as well as in the rest of the health plan. The plan deserves the support of this Committee and of Congress.

Chairman STARK. Thank you very much. It is reassuring that you for a while were on the White House Task Force and that at least there was some real policy discussed during your tenure, I am sure, but the decision seems to have been made to spend a significant amount of money on long-term care, and there of course were a variety of options that might have been selected on how to spend that.

The proposal to spend \$65 billion for long-term care over 5 years is what seems to have evolved. Could you outline for us what other alternatives they talked about? If you can't specifically say what other options were considered there, what other options you feel might be available to this committee as we proceed.

Mr. WIENER. I think the primary other set of options, at least on the public sector side, are to expand coverage of nursing home care. There are three basic types of plans that have been put forward

One, embodied in the proposals of the Pepper Commission, would cover the first 6 months of nursing home care. Most people who are discharged alive from nursing homes have relatively short stays, and that would completely cover the nursing home costs for most of that population.

Chairman STARK. Let me interject there—yes, I do have an opinion on this but I guess I don't really care. In the Pepper Commission deliberations—and I was a member of that commission—there were two distinct groups. One that said "Let's in effect cover the first 6 months of a nursing home episode, and let people either then spend into Medicaid or use their own resources after that or make people have a copayment or deductible or be responsible for the initial 1, 2, 3, 4, 5 months, strictly a function of cost," and I think what we found was if we made the public feel responsible for the first 2 months of a nursing home and the Federal Government paid everything beyond that, it was about the same cost as providing the first 6 months.

Mr. WIENER. Mr. Chairman, I don't think your memory serves you right there.

Chairman STARK. OK.

Mr. WIENER. The incremental Federal cost of covering the first 6 months of nursing home care would be on the order of \$4 billion. With the 2-month deductible and then unlimited coverage, you are probably talking about \$25 to \$30 billion.

Chairman STARK. At least. I think it was higher than that. So the 6 months was really cheap is what you are saying?

Mr. WIENER. Yes. By definition, you have everyone who walks in or is carried in the door gets some coverage, but the number of days that those is in that first 6 months is relatively small. The vast majority of days are in the long stay.

Chairman STARK. OK. I guess the way we could have saved money is to let them cover the first 6 months, that would have saved us some money, and then we only carry the long term liability for after 6 months. At any rate, my feeling was that seniors, we seniors would have been more secure knowing that if we could somehow manage the first couple of months or if we were very poor Medicaid would pay anyway and we would much prefer the removal of that uncertainty or that fear of the long-term internment

in a nursing home, do you have any feelings about which might be the better benefit?

Mr. WIENER. I think it is largely a matter of cost. As I indicated, the first 7 months, first 6 months coverage is relatively cheap. You could do that probably for another \$5 to \$7 billion. If you are going to do the whole banana, though, you are talking about \$25 billion, \$30 billion, \$35 billion, just on the nursing home.

Chairman STARK. That is what we were talking about.

Mr. WIENER. The advantage of complete coverage is that you don't fool around; you do the job, you protect people against catastrophic costs, and the downside is the large cost. The attractiveness of the short, front-end coverage is that it provides financial protection to people who have a chance of living some life in the community after they are in the nursing home. Virtually all of the people who are discharged alive and return to life in the community have relatively short stays.

Chairman STARK. OK. Let me try one other statement that I have used from time to time and see how it rests on your academic shoulders. That is to suggest that long-term care, nursing home care, is not necessarily a medical problem, that the amount of physician care and the amount of pharmaceuticals and the amount of medical procedures may not vary a lot, and arguably people with long-term care use more, but the long-term care is strictly an issue of money, people who have enough money get a private room in a nice nursing home and people who don't have any money get a less nice room under Medicaid. The issue isn't the better delivery although in some States it is better than others, but the real issue is that most people don't have enough money.

It is not a problem for Members of Congress who get generous benefits, we have enough retirement income if we are here a while to pay the freight. Is that overly simplified?

Mr. WIENER. Long-term care contains a continuum of things from overtly medical kinds of services down to just help with eating and bathing and dressing, and there is a wide continuum. Over time the patients in nursing homes have become more severely disabled and have a higher level of medical needs than in the past. I would certainly expect that given the cost pressures that hospitals will be under, if the President's health care reform plan is passed, they are going to be trying to move subacute patients into nursing homes. But whether people get formal services in the home or in nursing homes clearly has a financial component to it. It also has a component about the level of informal support that is available. So—

Chairman STARK. I guess what I am saying is if a person has a \$60,000, \$70,000, \$80,000 worth of retirement income that is guaranteed, long-term care isn't a problem for them, is it?

Mr. WIENER. Well, that is correct, but if you think about who are the primary users of nursing home services and long-term care more generally, it is 85-year-old disabled widows, almost none of whom had \$60,000 or \$70,000 in income.

Chairman STARK. I guess I am just coming back to say if we gave those people the \$36,000 a year that it costs to stay in a nursing home or whatever it is now, their problem is solved.

Mr. WIENER. If you gave most people \$36,000 or \$40,000, most of their problems would be solved.

Chairman STARK. Well, no, not necessarily. I mean, you do that in some parts of this country and they still don't have hospitals available, they still have physicians who won't treat them for a variety of reasons. I mean, there are indeed that is not—

Mr. WIENER. There is clearly no doubt that part of what is involved here with long-term care reform is giving people the financial resources to get the services they need, and one of the problems on the nursing home side is that the costs are very high, 30,000, 35,000 average nationwide places like New York can be \$70,000. But there is also a financial barrier on the home care side because people have less flexibility in terms of adjusting their every day living style. So people can't afford to pay a lot for home care services. I think Mr. Clinton's proposal would clearly be a major step in the right direction on the home care side.

Chairman STARK. Getting back to my original question, what other things—I interrupted you—on the roads not taken. What did we miss?

Mr. WIENER. Well, one set of options had to do with expanding social insurance to cover more of nursing home care. The other option that received serious consideration was a voluntary nursing-home-only, government-run insurance program. The idea would be that it would be completely self-funded plan in which people would enroll at, say, age 65, and they would be entitled, after a certain waiting period, to a fairly modest set of benefits, maybe 30,000 dollars' worth of nursing home benefits.

Chairman STARK. Did you cost that out? What would that cost me when I turn 65?

Mr. WIENER. It would probably cost beneficiaries about \$70 a month.

Chairman STARK. Seventy dollars?

Mr. WIENER. Seventy dollars in terms of a premium.

Chairman STARK. They would get benefits that might equal a year's stay in a nursing home?

Mr. WIENER. That is right.

Chairman STARK. It would be interesting to compare that later with what the private insurance companies are offering, wouldn't it?

Thank you.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I listened to your testimony, and I confess that I came away wondering do you support the long-term care proposal that the White House made?

Mr. WIENER. Yes, I do.

Mr. MCDERMOTT. As the best alternative or the best that can be done for the moment?

Mr. WIENER. I think it is the best that can be done at the moment, but that is a political judgment which the people on this committee are better able to make than I.

Mr. MCDERMOTT. Being Irish, I always think of Murphy's law, and having been in legislative bodies in other places before I came here, I see this capped community long-term care benefit as uncertain. You mentioned the effectiveness of block grants and how useful they were. When you give a block grant to a State and say now

run an in-home health care plan, I can see the States setting these up and then when we might be a little bit short of money up here at the Federal Government level we decided to cut the block grants. I was out in the State legislature when people started cutting block grants, and I know that at that point States are in a real squeeze between the expectations of people who are receiving care and the fact that there is no longer any Federal money coming.

So the States have to come up with the money some way or cut the program. Having scrambled in the 1980s, from 1983 to 1987 as a Ways and Means Chairman in the State legislature, I have real concerns about a program that is set up in this way, and I would like to hear your response to that.

Mr. WIENER. I think there are a couple of responses.

First, I think that it is a very legitimate concern, and I have in the past written similar kinds of comments about the problems with these kinds of capped programs. But I think there is a very fundamental dilemma that we face in designing this kind of program, and that is basically this: The disabled, especially the nonelderly disabled, need and want an extraordinarily wide range of services. The broader the range of services that you provide, the more likely it is that someone is going to find something on the menu they want. Utilization will become extremely difficult to control, and therefore expenditures will be very difficult to control. If you provide a legal entitlement, then it is going to be extremely difficult to control expenditures over the long run. I think it is a difficult trade-off between a wide range of services versus the entitlement. If you had a narrower set of services, you could probably provide that on an entitlement basis, but you run the risk of not providing the disabled some of the services that they would need.

I guess I would make two additional points. One is that one of the differences I would hope in this kind of program from the other block grants is that by including all of the disabled population, both the elderly and the nonelderly, both the rich and the poor, that you would create a strong political constituency that would lobby hard to make sure that funding levels were maintained. Second, and this is not part of the President's proposal, but I think could be, it would clearly help if there were a dedicated financing source for the program.

Mr. McDERMOTT. Specifically for long-term care?

Mr. WIENER. Right, as with the Medicare and Social Security Trust Fund, basically the money would go into the trust fund and could only be spent for long-term care services. I think that would be a help in terms of guaranteeing that a certain level of services was provided. The difficulty is making sure that the revenue sources increase with the elderly population and the disabled population and with inflation over time.

Mr. McDERMOTT. I have another problem with a health care plan that doesn't take into account long-term care. That is why when we wrote the single payer plan that is before the Congress we included it.

Let me give you an example of the problem that I see. One day I got a phone call from my congressional office in Seattle from a family who had a 17-year-old boy with AIDS sitting in a Seattle hospital at the cost of \$800 a day under the CHAMPUS program.

He was not disabled enough, although he had mental symptoms, he was not disabled enough to require or to qualify for nursing home care. There was an intermediate care facility in the community that would give him the kind of supportive care he needed for something around \$140 a day. The rules and regulations of CHAMPUS said, "You are either in the hospital at \$800 a day or you are in a nursing home, we don't pay for anything else." So I got into a long discussion with the Navy and finally got to the admiral at the top who said, "Well, we will make an exception in this case." It seemed to me that that is precisely what is wrong with our system in many respects.

We make exceptions when in fact if you are looking at the continuity of care or the continuum of care that people need in their lives, it is very difficult to design an efficient system when you leave one piece out or you don't take care of the financing of that system on a dependable basis. It seems to me if you don't take care of this community care you are just going to back people up into hospitals, you are going to leave them there until they are sufficiently disabled that you can put them in nursing homes. I wonder how you, from a planning standpoint, from a policy standpoint, how you cannot want it to be part of the entitlement, part of health care we can never take away from you. But in community long-term care, well, we can take that away from you. How do you justify that?

Mr. WIENER. There was a lot of discussion in the task force and on the working group about the whole issue of integration after acute and long-term care services. In principle everybody was in favor of it.

There are really a couple of problems. The first is that, as a practical matter, it is really more of a slogan at this point than a reality in terms of knowing how to do it. We really don't have good models about how to integrate acute and long-term care services.

There are a couple of demonstrations, social health maintenance organizations, and On Lok in San Francisco. There are some replications of their approach, but we really don't know very well how to integrate acute and long-term care services.

Second, there was considerable discussion about putting the long-term care services in the basic benefit package and making it go through the health alliance. The overwhelming sense among the people working on long-term care was that the acute care world didn't know very much about long-term care. They would have too strictly medical a model. They would not devise the kind of services that people really needed, and, therefore, it would be dangerous to give the total control of long-term care over to the acute care sector.

The fact of the matter is that the expertise in managing and running and designing long-term care in this country as well as other countries is really at the State and more local level, and that is where the President's plan puts the responsibility. There is the worry and the anxiety the administration is exacerbating the disjunction between the acute care sector and the long-term care sector, between Medicare and the home and community-based services.

That is a difficult trade-off, and it is one that the task force did struggle with.

Mr. MCDERMOTT. If I understand, reading between the lines of what you are saying, is that the insurance industry that is so involved now in HMOs in this country simply didn't want to take on this responsibility because they had no experience in it. They would rather deal with acute situations that they knew something about and leave the long-term care to the State; is that fair?

Mr. WIENER. I am not going to speak for the insurance industry, but the working group's view was that the acute insurance industry would put too low a priority on long-term care. They didn't have much experience with it. We really need to build on the system that we have which is a State-run kind.

In general the private health insurance market is going to have its hands full dealing with 37 million people who have been uninsured and with the very major change in incentives that the President has proposed.

Mr. MCDERMOTT. That is a real interesting phenomenon that they want to take care of acute care or they think they know how to handle acute care but they can't figure out actuarially how long it is going to take and how much it is going to take to deal with people. Since they have all the actuaries and all the folks who predict these sorts of things, why they wouldn't be able to make those kinds of judgments and cost it out.

Mr. WIENER. I am not sure it is so much a question of costing it out as that it is a different mind set. We are talking about giving people a choice over the fundamental aspects of quality of life—eating, bathing, dressing, things of that nature—trying to give people some control over their life, and I think the medical model we have in acute care just doesn't work very well on long-term care.

If we just turn over responsibility for long-term care to the health insurance industry or to the acute care sector more generally, I don't think we are going to get the kind of long-term care services that we would like.

Mr. MCDERMOTT. I see a problem down there that we haven't resolved.

Thank you, Mr. Chairman.

Chairman STARK. Josh, what proportion of the long-term care population do you expect would be served under the proposed block grant the President has?

Mr. WIENER. Under the President's cost estimates, about 3 million severely disabled persons will be served, of whom about 70 percent will be elderly and about 30 percent will be nonelderly.

Chairman STARK. That is not my question. How many are there out there who ought to be served or who would need the services?

Mr. WIENER. I am sorry, who need services?

Chairman STARK. Yes. You said 3 million will get served. Are there 10 million out there who could use the services who won't get helped or is that everybody who we think is out there?

Mr. WIENER. Well, there are probably—I would have to go back and double check the numbers, but there is certainly something around 5 or 6, about 6 million disabled persons, perhaps more, depending on your definition.

The President's proposal uses a very strict definition of disability, not out of any particular principle, but just as a matter of trying to keep the costs under control. The President's budget plan calls for a fairly rich set of services for the participating individual.

Chairman STARK. Those are currently disabled?

Mr. WIENER. That is right, that is the 1993 numbers.

Chairman STARK. If you had to field a guess, what would some actuary tell me that in the over 50 population are people we can anticipate in any 1 year who will need nursing homes who aren't currently disabled?

What is the population, another 4 or 5 million?

Mr. WIENER. I don't think I can answer that question. This is a steady state sort of number in terms of "on the average day" how many people would be receiving services.

Chairman STARK. Or need them; not receiving them. What I am trying to get at, you are saying these are 6 million currently disabled, so we are only getting half of them in the 3 million. Now, how many are going to just need long-term care because of a stroke or because of recovery from an accident or something else that they may—I guess they become disabled at that point under the definition. Another 4 million?

Mr. WIENER. There is in fact a good deal more movement in and out of disability than people currently often think.

Chairman STARK. I am trying to get an accurate figure. Somehow the figure 10 million sticks in my mind if we were going to say we were going to provide long-term care, the population in a year who needs it might be up in the neighborhood of 10 million. Is that a—

Mr. WIENER. I think the number of users during the course of a year is probably more like four, would be four or five under the President's proposal.

Chairman STARK. In addition to the six?

Mr. WIENER. You have to distinguish between sort of average daily use, which is essentially these numbers.

Chairman STARK. Let me put it this way: He is going to serve a certain number of people he estimates, right? It is in his block grant.

Mr. WIENER. That is correct.

Chairman STARK. My question is you don't think that is going to be everybody who needs the services, right? I am just trying to find out—

Mr. WIENER. The cost estimates a very high level of participation. Nearly 80 percent of the people who would meet the disability criteria will, in fact, receive services in the cost estimates, and they will receive a fairly generous level of service.

Chairman STARK. And what about the current Medicaid population in nursing homes?

Mr. WIENER. Well—

Chairman STARK. Are they in that 3 million?

Mr. WIENER. No, they are not. These are home and community-based persons only.

Chairman STARK. But they will be covered under this block grant, will they not?

Mr. WIENER. You cannot use this block grant or this new program to finance institutional services.

Chairman STARK. How are the Medicaid—and the new beneficiaries stay in Medicaid so they are not covered. So you are saying approximately half of the people will get services?

Mr. WIENER. Well, but I guess I am having a little trouble using—going from “average daily census” here to users “during the course of the year.”

Chairman STARK. You mentioned that you think there are 6 million disabled out there.

Mr. WIENER. There are approximately 6 to 10 million, depending on—

Chairman STARK. Who would qualify? You think there are about 3 million?

Mr. WIENER. No, I am saying there are roughly 3 million people who have three or more problems with the activities of daily living or substantial cognitive impairment.

Chairman STARK. All right. There are how many people with three ADLs; 3 million?

Mr. WIENER. Approximately 3 million.

Chairman STARK. OK. But then what you are saying, where did the 5 or 6 million figure come from?

Mr. WIENER. Well, you asked me how many total disabled persons there were, and I will go back and provide you an answer for the record, but 6 or 8 million.

Chairman STARK. OK.

[The following was subsequently received:]

The total number (elderly and nonelderly) of noninstitutionalized disabled persons is about 10 million. Approximately 3.1 million of them would qualify for services under the Clinton administration proposal.

Chairman STARK. So of that 6 or 8 million what you are telling me is that only 3 million will be covered under this plan?

Mr. WIENER. That is correct.

Chairman STARK. All right. That is what I was getting at. So we get about half?

Mr. WIENER. That is correct.

Chairman STARK. Is it fair to just double the amount? Is it linear? If we double the amount will we get them all?

Mr. WIENER. You wouldn't double the amount because the more severely disabled population uses more services, but the problem gets to be as you provide coverage for less disabled people, you tend to get more people covered.

Chairman STARK. OK.

Let's go to long-term care insurance for a moment. You are familiar with the state of the art in long-term care, commercial long-term care insurance?

Mr. WIENER. I am trying.

Chairman STARK. What do you think of this idea to have an offer of inflation protection as opposed to requiring that in any policy?

Mr. WIENER. Well, as you may recall, I have testified before this subcommittee several times suggesting that that inflation protection be mandatory. The ravages of inflation are so devastating to the value of the indemnity level that I think it is absolutely essential to have inflation protection. I don't think an offer is adequate.

Chairman STARK. I don't, either. Can you describe the nonforfeiture requirement—if there is one in the President's plan; I think there is—and put in layman's terms for us, just for the record why we ought to have that.

Mr. WIENER. Basically the President's proposal requires that long-term care insurance policies have a nonforfeiture benefit. My recollection is that there is not a specific kind of nonforfeiture benefit, but that is something that has to be worked out by the advisory panel. The basic idea is that long-term care insurance typically has a level premium and builds up reserves.

What happens unfortunately is that substantial numbers of people buy a policy, pay for some period of time, and then drop the policy. You have a couple of problems with that. One is that people will have overpaid for the actuarial benefit that they received.

Chairman STARK. In the early years?

Mr. WIENER. The other is that it creates an incentive for agents to make the first year sale and then not to care about whether people continue. The lapse rates that the industry typically assumes in pricing their policies are fairly high in absolute terms, although they may not be much higher than what you get with life insurance. My position is that we cannot begin to take long-term care insurance seriously if they are going to assume that the majority of people who initially buy a policy are not going to have it when it comes time to use the benefits.

Chairman STARK. Are you familiar with the history of life insurance in this country?

Mr. WIENER. Somewhat.

Chairman STARK. Is it not correct that in the good old days, whenever those were, that the life insurance industry did not pay forfeiture benefits, that you had a level premium but if you quit you didn't get anything back, and they were building up excessive reserves, at least in the opinion of the regulators, I think it was in the early part of this century, and it was in fact the insurance regulators who required the life insurance companies to pay the cash to create the cash value or the loan value over the strenuous objection of the insurance companies.

It is a feature which they now tout over the kitchen table through their sales people, but it was true that the regulators had to force the life insurance people to provide nonforfeiture benefits, isn't that your understanding? Win.

Mr. WIENER. That is my understanding of the history, and in fact the National Association of Insurance Commissioners has recently endorsed nonforfeiture benefits in principle and is working out the regulatory details. At this point I don't think any State requires nonforfeiture benefits.

Chairman STARK. Have you any idea what combining these two, the inflation benefit and a reasonable, let's say nonforfeiture at least as reasonable as we do for life insurance, what that would do to the premiums?

Mr. WIENER. These are added benefits. Nonforfeiture benefits would probably increase the premiums by a third. Requiring a 5 percent compound inflation adjustment at age 67 would probably double the premiums. At age 40, it probably would quadruple the premiums.

It is not hard to see why there is resistance here. We are talking about a product which is relatively expensive to start with and then substantially adding to the costs.

Chairman STARK. Would you add any opinion as to—well, how you sell that stuff is—I will leave to experts other than yourself.

Welcome, Mr. Levin. Did you have any questions for Mr. Wiener?

Mr. LEVIN. No.

OK.

Josh, thank you very much. We appreciate your testimony and look forward to working with you as we proceed through this thick-et over the next year or so.

Our next panel will be comprised of four witnesses: Ms. Ruth Scarborough is a member of the board of trustees of the American Association of Retired Persons; Ms. Jenifer Simpson is the policy associate of the United Cerebral Palsy Associations, Incorporated; Mr. Stephen McConnell who is the chair of the Long-Term Care Campaign, and senior vice president for public policy at the Alzheimer's Association; and Mr. Max Richtman, the executive vice president of the National Committee to Preserve Social Security.

We welcome the witnesses to the committee and ask that you summarize your testimony or expand on it in any manner that you are able.

Mr. McDERMOTT. Mr. Chairman, I want to note that Ms. Scarborough is from the second best city next to Oakland, and we welcome you. She is from Seattle. Glad to have you here.

Ms. SCARBOROUGH. Thank you.

Chairman STARK. We welcome all of you to the committee. We will hear from Ms. Scarborough. Will you proceed?

STATEMENT OF RUTH SCARBOROUGH, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. SCARBOROUGH. Thank you, Mr. Chairman.

I am Ruth Scarborough of Washington State, as has been recognized, and a member of AARP's board of directors. Before commenting on the President's proposals for long-term care, I want to speak to an issue on your minds and certainly on ours, and that is cost.

We know that policymakers are sensitive to the need for long-term care coverage. Many of you have personal experience or friends who have had to cope with the financial and emotional stresses, and often the devastation, involved in meeting long-term care needs.

As policymakers, however, we naturally translate the subject of long-term care into a vision of Federal budget dollar signs. Our families also see dollar signs. They see huge dollar signs when they struggle to pay for home care for a child, a spouse, or a parent while still dealing with college tuition costs and a home mortgage. They see even larger dollar signs when faced with the often bankrupting costs of a nursing home stay, but the dollar signs don't stop there.

Equally important is the cost the care givers bear—wives, daughters, spouses, mothers—and in turn the cost to our economy. We pay in lost wages, and the Federal Government pays in lost tax

revenue. We pay in lost or reduced pensions and in lower Social Security benefits.

The Federal Government, and we as taxpayers, also pay in high assistance costs later. The President's proposal for a new home and community-based long-term care program recognizes that few families can afford the costs of such care and that the need may involve a child born with a developmental disability, a traumatized accident victim or a family member with Alzheimer's disease.

Appropriately, the proposal focuses eligibility on measures of disability, not age or income. While we are still assessing the proposal, there are a number of areas with which we have concerns.

First, the President proposes, in effect, an annual matching grant to the States rather than a direct payment to or on behalf of an individual. States have the choice of whether to participate at all.

Second, we are concerned about the nature and funding the program. Would funding be subject to annual appropriation and sequestration? Would it require cutbacks in other appropriated programs or an annual increase in the discretionary caps? Are inflation, population, and other factors such as intensity of service need and real wage growth adequately reflected in the program's budget estimates?

An initial review leaves us concerned that they are not. What happens to individuals receiving care if the funds run out before the end of the fiscal year? Would services simply be cut off? Would these individuals have to reapply for the next year?

We also have concerns about the role of the States. What happens to those who needs long-term care if the state chooses not to participate? While many States would see this as an opportunity, some States might be reluctant to take on the new program. While we agree with the administration that there is merit in State administration of a home and community-based program, State flexibility must be balanced with clear Federal guidelines and oversight.

States should meet certain basic Federal standards regarding provision of basic services, data collection, monitoring and quality of care.

Federal oversight should include review of State plans and the compliance with these and with Federal standards. Federal enforcement measures should also be available. Although the AARP is generally supportive of the modest attempts in the plan to improve Medicaid nursing home benefits, millions of Americans would remain vulnerable due to lack of protection against enormous nursing home costs.

Studies conducted for AARP by DYG, Incorporated, found that while families prefer home and community-based care, their greatest fear is the impoverishment of nursing home costs—averaging 30,000 a year, which can exceed 60,000 in some parts of the country. This fear is related to the willingness to pay increased taxes to finance new benefits.

In light of these concerns, it is important to remember that while modifications are needed in this proposal, it is a vast improvement over the current long-term care nonsystem. Notwithstanding the proposal's limitations, we believe that the President has made a se-

rious start toward achieving security against the overwhelming cost of long-term care.

It is, however, a long way from meeting the full extent of the need. We should be candid with the public and not attempt to oversell the President's long-term care proposal. Its limitations will loom larger in the public's eye in the future if they come to believe that there is more coverage and protection than really exists.

In conclusion, Mr. Chairman, AARP commends the President and the Members of both sides of aisle that brought the debate to this stage. As we go forward to refine and enact this reform, we ask you to consider the impact to American families of not including long-term care in health care reform. Our job is to shape and improve the proposal so that it will begin to provide security and protection now and a solid foundation for the future.

If there is one thing we should agree on, it is that the status quo is not an acceptable option. AARP looks forward to working with the members of this committee and the Congress to assure that long-term care remain an integral part of health care reform.

Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

**STATEMENT OF RUTH M. SCARBOROUGH
AMERICAN ASSOCIATION OF RETIRED PERSONS**

Good Morning. My name is Ruth Scarborough, and I am a member of the Board of Directors of the American Association of Retired Persons (AARP). Thank you for the opportunity to testify today as the Committee reviews one of the most critical problems facing families today: the need for long-term care.

Over the past several years we have listened closely to what our diverse membership and their families, as well as the American public, tell us they want in a health care system. Despite their differing circumstances, the vast majority of Americans, old and young, have consistently stressed the need for broader protections against the high costs of health and long-term care. Some assume that concern about and support for long-term care coverage is confined primarily to the older population, but, in fact, the 50-64 age group is even more worried, both for their parents and themselves.

AARP commends President Clinton for his bold and constructive plan for accomplishing reform. We also commend the First Lady, Congressional leaders in both parties, and this Committee for a commitment to addressing this issue now. The nation has waited too long for comprehensive reform. We must use this unique point in history to enact true reform which covers everyone, maintains high quality care, makes health care costs affordable, and includes coverage of both prescription drugs and long-term care.

The inclusion of long-term care is vital to our members and their families and is critical to AARP's support for any health care reform proposal. Unfortunately, many Americans still equate long-term care with nursing home care. Long-term care, however, is much more than just nursing home care. It includes a wide range of home and community-based care as well as residential alternatives.

AARP is pleased that the President's proposal includes coverage for home and community-based care for persons of all ages and incomes. Too many reform proposals focus only on acute care and simply ignore the long-term care needs of American families. These proposals are fundamentally flawed because they fail to address the need for a full continuum of care throughout an individual's life. Without long-term care coverage, no family has real security against the crippling costs of serious illness or disability. The President's proposal represents a serious start towards addressing the unmet long-term care needs of millions of American families.

Long-term care is typically considered a benefit for the elderly. This is a myth -- the need for long-term care crosses generational lines. An estimated 10 million persons need some form of long-term care; approximately one-third of these individuals are under age 65. Many are children. Moreover, the need for long-term care is felt not just by those requiring care, but also by their families -- often those providing and paying for care. This is particularly true in the case of those in the "sandwich generation," caught between meeting the needs of their children and their parents.

Health Care Reform Must Include Long-Term Care

While approximately 37 million people lack basic medical insurance, virtually all Americans lack protection against long-term care expenses. To a family sitting around the kitchen table, there is no difference between spending \$20,000 on hospital care and spending \$20,000 on home care. It is still \$20,000 they do not have. Therefore, to achieve true security, savings, and quality in our health care system, care must not be limited to the provision of services by a hospital or doctor; long-term care must also be included.

The need for comprehensive services -- It makes little sense to provide financial protection against the cost of an acute illness but leave people vulnerable if they suffer from a chronic and disabling condition, especially since the need for these services often is so interrelated. Results from research conducted on the Social Health Maintenance Organization (SHMO) demonstrations in the late 1980's illustrates why integrated care is so important -- custodial and skilled services are often needed to complement one another. Almost 70 percent of

initial referrals for community-based long-term care originated from hospitals and other parts of the medical care system. Moreover, 37 percent of the care plans developed for home and community care included concurrent authorization for medically necessary skilled services. In addition, individuals' level of disability frequently changed and was tied to acute episodes of illness. Without comprehensive benefits, patient care will not be effective, and costs "avoided" in long-term care may instead show up as costs in the acute care setting.

Families cannot afford long-term care -- With average annual nursing home costs of \$30,000 (and some areas experiencing costs of \$60,000 or more) and home health care costing from \$50 to \$200 per day, long-term care out-of-pocket costs can often devastate a family. For most people, the cost of long-term care is an unmanageable financial burden. Many families are also shocked to find -- only too late -- that neither Medicare nor private insurance covers long-term care to any great extent.

Caregivers are being unfairly burdened -- Family members provide the vast majority of long-term care to persons of all ages. But caregivers place their own health in jeopardy and frequently are forced to leave the labor market, thereby suffering not only short-term loss of income, but also long-term reduction in Social Security and private pension benefits.

In a recent focus group, a woman in her 50's related her story:

Rose had held a good job with a large corporation until her mother needed long-term care to persons of all ages. But caregivers place their own health in jeopardy and frequently are forced to leave the labor market, thereby suffering not only short-term loss of income, but also long-term reduction in Social Security and private pension benefits. She saw her future income potential and retirement security disappear as she made the painful decision to take care of her mother.

There are many stories just like this. They typically involve women in their 50's -- primarily spouses and daughters -- who sacrifice financially, physically, and emotionally to assure that a loved one is cared for. The Association believes that caregivers deserve strong support.

Private sector solutions cannot work -- The private market has not and cannot provide adequate and affordable protection against the cost of long-term care. Private long-term care insurance that provides meaningful coverage is very expensive and generally excludes people with pre-existing conditions or mental disorders. Few people can afford the cost of private long-term care insurance for any length of time, particularly if the policy is of good quality. These policies have done a particularly poor job in trying to cover home care because insurance companies are not confident in their ability to control the risks and demand involved.

Public Support for Long-Term Care

Americans of all ages strongly support health care reform that includes coverage for long-term care. A survey conducted for AARP this past April found that 90 percent of the respondents felt that including long-term care in a health reform proposal was important. Support for health care reform increased from 46 percent to 82 percent when long-term care was included (See Attachments 1 and 2). More recently, in a poll conducted for AARP in October, 86 percent of respondents in California stated that they would be less in favor of the President's health care proposal if it included no coverage for long-term care.

According to a survey conducted in the fall of 1991 by DYG, Inc., three-fourths of Americans (18 and older) were "very concerned" about paying for the cost of long-term care. The concern, which is felt sharply by both men and women, extends to all income and age groups. In fact, concern about long-term care was greatest among persons age 50-64 -- those most likely to be caring for older parents and worrying about their own futures (See Attachments 3-7).

In a Harris survey conducted during December 1992 and January 1993, 91 percent of the respondents said they could not afford long-term care when they were told it would cost \$15,000 to \$60,000 a year, or \$40 to \$160 a day. With regard to a federal program providing long-term care in the home for the chronically ill or disabled, over 80 percent of respondents favored such a program not only for people 65 years of age and older, but for adults and children as well.

AARP Views on Long-Term Care

To make long-term care coverage affordable and accessible to all Americans, the Association believes that the ideal solution is a social insurance program, similar to Medicare and Social Security, that would provide a comprehensive set of benefits in the home and community, as well as in nursing homes. A social insurance program would require financial contributions from all members of society and would provide protection to all who need long-term care, regardless of age or income. Such an approach would spread the risks so that the costs to any one person would be small, while offering protection and appropriate care to all. Under such a social insurance system, private sector initiatives would supplement the public system by covering coinsurance, deductibles, and additional needed services.

Other fundamental principles which underlie AARP's views on long-term care include: (1) provision of a comprehensive range of services, including institutional and home and community-based care; (2) financing which is equitable, broadly based, and affordable to all individuals; (3) coordination between the acute and long-term care systems to assure a continuum of care across an individual's lifetime; (4) assurance of high quality care; (5) effective cost containment mechanisms; and (6) support for informal caregivers.

These principles are at the foundation of AARP's proposal for comprehensive health care reform -- "Health Care America." The proposal was developed with the extensive involvement of AARP members across the country. The long-term care provisions of the proposal include comprehensive coverage through a new Medicare-like program. Eligibility for a full range of home and community-based services would be based primarily upon dependencies in 2 of 5 Activities of Daily Living (ADLs). Nursing home protection, excluding coverage for room and board, would be available over the entire length of an individual's stay.

The President's Proposal for Home and Community-Based Care

The President's health care reform proposal is a serious start toward meeting the unmet long-term care needs of millions of American families. While it clearly does not address the full extent of need for long-term care, the proposal is a dramatic improvement over where we are now.

The Association believes that, given limited resources, the President is on the right track in basing eligibility for the new home and community-based program on levels of disability, rather than age or income. An eligibility assessment and determination based on level of disability, when combined with the proposed care plan, would begin to address the serious problems of fragmentation and unmet need that currently exist for disabled persons of all ages. Age is not a viable eligibility criterion because approximately one-third of the severely disabled who need home and community-based care are under age 65. In addition, because the program is not based on a welfare model, those in need will not be forced to bankrupt themselves before getting help, as they must do now to be eligible for Medicaid.

The President's proposal is a good starting point on long-term care. Unfortunately, many of the other health care reform proposals -- most notably H.R. 3222, the Managed Competition Act, and H.R. 3080, the Affordable Health Care Now Act -- fail to include meaningful long-term care reform. We commend the authors of H.R. 1200, the American Health Security Act, for proposing to provide comprehensive long-term care for all in need, including nursing home coverage. But this proposal includes a \$65 monthly premium, which persons

over age 65 with incomes above 120 percent of poverty would have to pay. Such an expensive, "elderly-only" premium would clearly be unaffordable for most.

The President's proposal for home and community-based care would provide much needed support to caregivers who are shouldering enormous burdens by taking care of their loved ones and often missing work to do so. Many caregivers perform these services out of a strong family commitment and a desire to postpone nursing home placement for as long as possible.

The President's home and community-based care proposal would begin to provide to disabled persons and their families real choices about how to arrange for and where to receive the most appropriate care. Today people are being forced into nursing homes prematurely or going without care because they do not have access to affordable home and community-based care. Historical patterns in public spending reflect a perverse bias, where approximately four out of five dollars spent on long-term care go to institutional care. This creates situations in which families are broken apart and Americans are denied care in the most appropriate setting, as well as where they would like to receive it. For the first time, under the proposal, many disabled Americans could receive services through the full continuum of care.

Concerns With President's Home and Community-Based Care Proposal

At the same time the Association applauds the President for recognizing the need to expand coverage and options for home and community-based care, we have specific questions and concerns about the proposal. We look forward to working with the Administration and the Congress to answer these questions and attempt to address these concerns.

We agree with the need to contain long-term care costs and to keep federal expenditures under control, given limited resources. Effective care management and appropriate provider reimbursement should help in this regard. However, certain elements of the proposal that are designed to reduce program costs and others relating to the role of the states raise particular concerns.

PROPOSALS TO MINIMIZE PROGRAM COSTS

Caps on Funding -- The proposal is, in effect, a capped block grant to the states. We have questions about how this would work.

- Would funding be subject to annual appropriation or sequestration?
- Would the program be included under the PAYGO provisions of the Budget Enforcement Act?
- What would happen if the program ran out of money before the end of the fiscal year? Would services to persons currently receiving care simply be cut off?
- Would a requirement for reassessments between fiscal years interrupt continuity of care?

The capped nature of the proposed program makes it all the more critical that the data and criteria used to estimate full funding over time are accurate and sufficiently inclusive. Otherwise, funding shortfalls could easily occur, resulting in potentially serious levels of unmet need. The baseline estimates, for example, must include accurate cost and utilization assumptions for all groups of eligible persons, including severely disabled children.

The adequacy of inflation and trending factors are a concern because they do not seem to account sufficiently for future changes in the intensity of service needs or real wage growth among workers in the very labor intensive home care area. The irregular funding pattern in Section 2109 of the President's legislative proposal increases the level of our concerns. In addition, the inadequate historic funding levels for the Title XX Social Services Block Grant program, on which the home and community-based program is modeled, do not inspire optimism.

Phase-in Schedule -- The proposed eight-year phase-in period will also be of concern to many of our members. Quite realistically, they will wonder how much of the benefit they will receive. The original proposal had a five year phase-in, while most other provisions in the President's plan have a three year phase-in.

Beneficiary Copayments -- We recognize that beneficiaries must pay a meaningful coinsurance for this program; indeed our own Health Care America proposal included a 20 percent coinsurance. However, a 40 percent coinsurance is high compared to the copayments proposed in other parts of the President's health care reform package and could be prohibitively expensive for those with incomes just above 400 percent of poverty. It would appear that the jump from 20 or 25 percent coinsurance to 40 percent at these income levels produces only a small increase in offsetting receipts. In addition, virtually all eligible individuals would have to submit income data to receive services; creating a potential welfare stigma and increasing administrative burdens.

Definition of Disability -- The Association is pleased that the proposal would cover persons who need stand-by assistance or cueing to perform 3 or more ADLs. However, we would ultimately like to see a 2 of 5 ADL standard.

ISSUES REGARDING THE ROLE OF THE STATES

Option for the States -- It appears that states would have the option of not participating in the program at all. This could pose serious problems for consumers. Further, it is not clear what the states' financial obligation would be under the proposal. For example, poorer states, or those that do not fare well in the determination of state maintenance of effort, may elect not to establish a program or may postpone participation until much later in the very long phase-in schedule. The lack of state participation to date in the Section 4711 Frail Elderly program, which is an optional capped entitlement to the states, is not encouraging.

Variation and Fragmentation -- While we agree with the Administration that there is merit in state administration of the home and community-based program, to minimize the tremendous variation and fragmentation among states that currently exist, especially under Medicaid, the Association believes that state flexibility must be balanced by clear federal standards and federal oversight. Widely varying systems would result in disturbing geographic inequities. Federal standards should require the provision of basic services, promote efficiency, and assure that consumers are protected. Federal oversight should include review of state plans and monitoring of compliance with federal standards. Careful reporting of substandard performance or troublesome trends should be accompanied by strong enforcement tools. Particular attention should be paid to monitoring states so that they do not simply shift just eligible current Medicaid recipients into the program in an attempt to realize windfall savings.

State Incentives for Residential Care Alternatives -- One way to promote savings through competitive market forces would be to provide strong incentives to assist the development of residential alternatives to nursing home care, such as assisted living. Experience in Oregon, for example, has shown assisted living to be a cost effective, preferred alternative to nursing home care for many frail elderly. Although we are pleased that the home and community-based care benefit proposed would be portable and available to eligible persons in these settings, more needs to be done on the capital and housing side of the equation. Ways to make such residential options affordable to persons with low and moderate incomes should be specifically addressed.

Nursing Home Care and Medicaid Improvements

In addition to a new program for home and community-based care, the President's proposal also would include modest improvements for those who need nursing home care. Specifically, it would: (1) require all states to have medically needy programs under Medicaid; (2) give states the option to increase the level of protected assets for single persons from \$2,000 to \$12,000 for purposes of Medicaid eligibility; (3) increase the minimum

Medicaid personal needs allowance from \$30 to \$70 (scaled back from \$100 in the September draft); and (4) create new uniform federal minimum standards for private long-term care insurance policies, together with certain tax clarifications.

Although AARP is generally supportive of these modest attempts to improve Medicaid, millions of Americans would remain vulnerable to impoverishment due to lack of protection against enormous nursing home costs. The single greatest fear which families confront in long-term care is the devastating costs of a nursing home stay, which now averages \$30,000 a year and can exceed \$60,000 in some parts of the country. Studies conducted for AARP in 1989 and 1991 by DYG, Inc. found that while people prefer home care, it is the cost of nursing home care which individuals fear most when they consider their long-term care needs, and it is this concern that appears most related to their willingness to pay increased taxes to finance new benefits.

AARP strongly supports the requirement for uniform federal standards for private long-term care insurance. Such reform is long overdue. Findings from studies conducted by the U.S. General Accounting Office, the Office of the Inspector General, and by Project Hope for AARP clearly demonstrate that the current state regulatory system has failed to provide sufficient consumer protection throughout the nation. We do, however, have some questions about the costs and distributional effects of the tax clarifications proposed in this area, particularly for those selling insurance policies.

Incremental Nursing Home Reforms -- If sufficient funding for a comprehensive nursing home program is not available at this time, additional incremental reforms could also help many people. For example, one option would be to reduce the inappropriately high \$84.50 Medicare Skilled Nursing Facility daily coinsurance and make it more consistent with the extended care benefit available in the President's proposed basic benefit package through the alliances. We also strongly urge that the proposed optional increase in the level of assets protected under Medicaid for single persons (from \$2,000 to \$12,000) be made mandatory, as was originally proposed in the September draft, since states are very unlikely to provide such protection voluntarily. In our view, the amount should be increased beyond \$12,000 so that people need not spend-down to such a low level before receiving protection.

The President's proposal should also do more to promote the key principles of savings and choice for Americans who need nursing home care. The proposal does not address the need to contain nursing home costs, nor does it remedy the access problems that low and middle income applicants experience in gaining admission to the nursing home of their choice. Hospitals and other providers will have incentives to shift costs to this sector if it is the only one not subject to some form of spending limits. These goals could be furthered by making charge data available to consumers and prohibiting discrimination in admissions on the basis of wealth and source of payment.

Conclusion

On June 8, 1988, the late Senator Claude Pepper brought a bill covering home and community-based care to a vote on the House floor. Much was said by many members about the need to provide this kind of protection. Even opponents, who argued that the timing was not right, spoke eloquently about the importance of covering services in the home. Just before the proposal was defeated by a 169-243 vote, Congressman Pepper stated:

This is a day for which I have waited and worked, and I might say prayed for, for 50 years -- a chance to lighten the burden upon the masses of the people of this country, trying to help those saddled with a long-term illness....We can help millions of people to meet crises in their homes that are heart-rending in their character. When are we going to have another opportunity if we lose this one?"

The opportunity has now come. As advocates and policymakers we will, however, need to be very candid with the public and not attempt to oversell the President's proposal on long-term care. The limitations of this program will loom larger in the public's eye in the future

if they come to believe that there is more coverage and protection in the program than really exists. The President's proposal does not provide all the answers for everyone in need. But it is a significant start and a vast improvement over our current long-term care "non-system". Our job is to shape and improve the proposal so that it will provide real protection now and a solid foundation for the future.

We have a chance to begin to create a new system that removes the existing bias in favor of placing people in institutions for the rest of their lives; a system that does not force people to bankrupt themselves and go on welfare in order to receive help; a system that does not force caregivers to quit their jobs or jeopardize their own health to continue caring for loved ones; and a system that is not fragmented and intimidating for those who need to use it.

AARP looks forward to working with members of this Committee to help realize these goals and ensure that long-term care remains an integral part of whatever health care reform package is enacted.

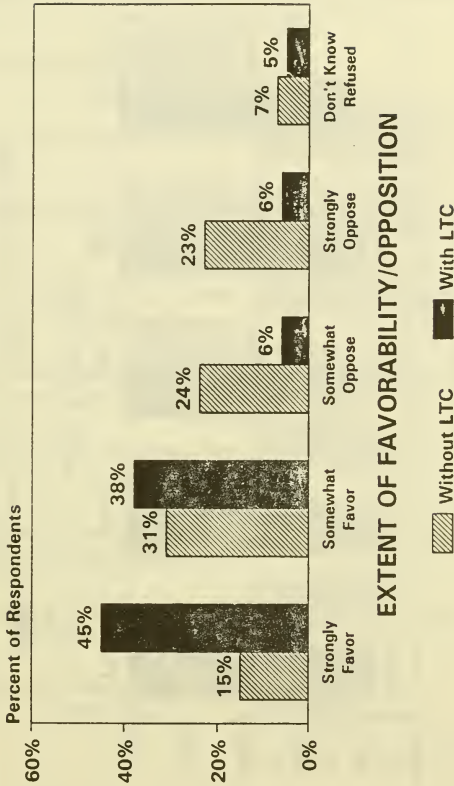
It is our hope that the new system will enable us to track the care individuals receive in a uniform manner over the full continuum of settings and services.

Surveys have also demonstrated that the public is willing to pay for a social insurance approach if the program provides the benefits that are needed most. A 1989 survey by DYG, Inc., for example, found that Americans are willing to pay increased taxes for a long-term care package that would provide comprehensive coverage for all Americans.

Another DYG survey conducted for AARP in the fall of 1991 and winter of 1992 found that respondents had less confidence in the long-term care system than they had in the acute care system and that the nature and comprehensiveness of the benefit package was a major factor in determining willingness to pay.

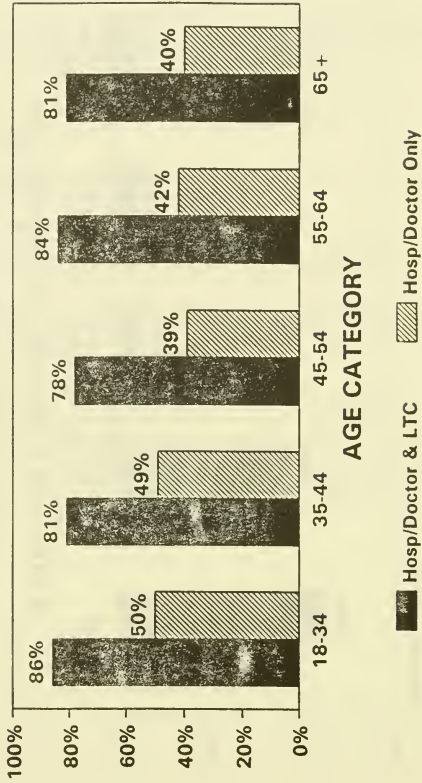
Serious needs are not being met -- Perhaps most important is the hidden cost associated with the suffering, deprivation, and isolation for those in our society who get no care or inadequate help. Data from the 1989 National Long-Term Care Survey indicate that large numbers of functionally impaired older persons in the community, particularly the severely disabled, have unmet needs for assistance. For example, 77 percent of older people with three or more limitations in their activities of daily living reported they needed more help than they were getting. In addition, the 1986 Longitudinal Study on Aging showed that 31 percent of persons over age 70 who had 3 or more ADL impairments received no help while 48 percent received unpaid assistance only.

FAVOR/OPPOSE HEALTH CARE REFORM PLAN WITH AND WITHOUT LONG-TERM CARE COVERAGE



AUS/ICR Survey Research Group
Excel Omnibus Study
April 21-27, 1993 (N = 2,020)

PERCENT FAVORING HEALTH REFORM PLANS WITH & WITHOUT LONG TERM CARE COVERAGE (BY AGE CATEGORY)

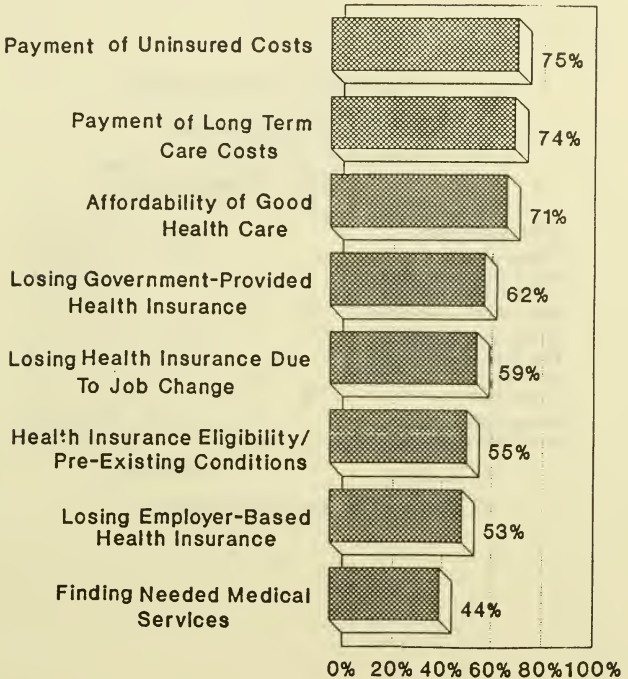


AUS/ICR Survey Research Group
Excel Omnibus Study
April 21-27, 1993 (N = 2,020)

Ratings of Health Care Concerns

Total Sample

Very Concerned About:



ATTACHMENT 4

Ratings of Health Care Concerns

	<u>Total</u> %	<u>Total</u> <u>Women</u> %	<u>Total</u> <u>Men</u> %
<u>Very Concerned</u> ^{1/}			
Being able to pay for costs of health care not covered by insurance/government	75	75	75
Being able to pay for the cost of long term care such as nursing home care	74	76	73
Being able to afford good health insurance	71	70	71

Continued...

^{1/} Rating of "4" on a 4-point scale

ATTACHMENT 5

Ratings of Health Care Concerns

	<u>Total Women</u>	<u>Women: Age</u>		
		<u>18-49</u>	<u>50-64</u>	<u>65+</u>
	%	%	%	%
<u>Very Concerned</u> ^{1/}				
Being able to pay for costs of health care not covered by insurance/ government	75	74	82	70
Being able to pay for the cost of long term care such as nursing home care	76	72	85	78
Being able to afford good health insurance	70	69	85	60

Continued...

^{1/} Rating of "4" on a 4-point scale

ATTACHMENT 6

Ratings of Health Care Concerns

	<u>Total Men</u>	<u>Men: Age</u>		
		<u>18-49</u>	<u>50-64</u>	<u>65+</u>
	%	%	%	%
<u>Very Concerned</u> ^{1/}				
Being able to pay for costs of health care not covered by insurance/ government	75	75	76	76
Being able to pay for the cost of long term care such as nursing home care	73	69	80	79
Being able to afford good health insurance	71	73	75	58

Continued...

^{1/} Rating of "4" on a 4-point scale

ATTACHMENT 7

Ratings of Health Care Concerns

	<u>Total</u>	<u>Income</u> <u>(\$Thousands)</u>		
		<u>Under</u> <u>25</u>	<u>25-</u> <u>49.9</u>	<u>50+</u> <u>+</u>
	%	%	%	%
<u>Very Concerned</u> ^{1/}				
Being able to pay for costs of health care not covered by insurance/ government	75	80	78	59
Being able to pay for the cost of long term care such as nursing home care	74	77	74	68

Continued...

1/ Rating of "4" on a 4-point scale

Chairman STARK. Mrs. Simpson.

STATEMENT OF JENIFER SIMPSON, POLICY ASSOCIATE, UNITED CEREBRAL PALSY ASSOCIATIONS, INC., ON BEHALF OF THE CONSORTIUM FOR CITIZENS WITH DISABILITIES, TASK FORCES ON LONG-TERM SERVICES/MEDICAID AND PERSONAL ASSISTANCE; ACCOMPANIED BY CHRISTINA A. METZLER, SENIOR LEGISLATIVE REPRESENTATIVE, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Ms. SIMPSON. Mr. Chairman, members of the committee—

Chairman STARK. Excuse me. I would ask all the witnesses—these mikes don't work very well unless you practically swallow them.

Ms. SIMPSON. I am Jenifer Simpson. I am here today to speak about long-term support services for my 8-year-old son Joshua who is with me. I will keep him here with me.

Josh is one of some 500,000 to 700,000 children and adults with cerebral palsy in the United States today and among the more than 2 million persons with developmental disabilities. These are severe disabilities that occur early in childhood. These people constitute some of the children, young people and adults with disabilities who need long-term supports.

I testify today both as a parent who provides care services to this child, and on behalf of the Consortium for Citizens with Disabilities, which as you may know is an national advocacy working coalition of over 100 service providers, parents, and other professional organizations which advocates on behalf of individuals with disabilities.

Chris Metzler is here with me today and she cochairs the task force on this long-term services issue.

Joshua needs a complex array of long-term supports integrated with his needs for acute health care. I am pleased with some of the things I see in the President's plan. I am particularly pleased with the commitment of resources for long-term services, but I want to tell you a little bit about what Joshua needs now and what we will need as an adult.

I have a lifetime view about the needs of this child with a disability. This lifetime view is critical for me and our society, as we approach health care reform, for I won't always be around to see that he gets what he needs.

In many ways, Joshua is a typical little boy. He likes computers and playing with toy trains, including watching "Thomas, the Tank Engine." He went trick-or-treating this weekend dressed as clown. He watches TV and he is social and alert and goes to school. He goes to summer camp and he does the kinds of things every other 8-year-old boy does. He is skipping school today to be here with me today.

What makes Josh different from other kids is his disability and our Nation's failure to fully support my decision and effort to raise him at home where he belongs.

Cerebral palsy is not a disease or illness. It is a lifelong disability that affects many, many activities of daily living. It make it impossible for Joshua to walk, talk, eat, drink, use the bathroom, play,

or do anything without some help or assistance, and I am the person doing most of that.

I also work full time. I am a single parent and I find increasingly that I must pay others to provide the personal assistance services that he needs. As I get older, I cannot handle the stress of being the care provider, service coordinator, and working a full-time job that supports both of us. Joshua and I need support.

There are several concerns that we have, and the first one is about copayments. The plan proposes a series of copayments based on income to help States provide more long-term services. These copayments could go up to 40 percent for those over 400 percent of poverty and then there is no cap on this.

As a middle-income single parent, the thought of this terrifies me as I might be expected to pay 40 cents on every dollar of the complex costs of Joshua's long-term service needs. There are other concerns such as his need for assistive technology such as an augmentative communication device. Other children might require \$30,000 a year or more in costs for necessary services such as nursing, respirators, or other technology for children with chronic conditions. With this lack of caps on copayments, the costs quickly become prohibitive.

I don't see the alternative as institutionalization. I have been told to institutionalize my child many times by well-meaning professionals. Medicaid would fully pay for this as it would under the President's reform proposal. Remaining at home with me has enabled Joshua to lead a regular life and go to school. I expect him to have a productive life, get married, and live on his own. But I am disappointed the proposed program will still allow for complete coverage of institutional care for families who cannot provide for their child any longer.

This imbalance leaves open the possibility that someday I or Joshua will have no choice but an institution. I don't choose that now and I want to do everything in my power to change that bias so that it doesn't threaten Joshua. I am not sure if Joshua and other children will be able to get the assistive technology he needs. He needs a specialized communication device.

I am currently wrangling with the insurance provider about this today. He needs a prone stander, prosthetic braces—they are in his bag now. They cost \$2,000. He needs special adaptations to his wheelchair and other critical technology devices. Sometimes he needs customizations to his wheelchair, evaluations and maintenance. I am concerned about whether the proposal fully covers these needs. Without them he cannot be fully functional.

Another concern that we have is the rehabilitation therapies he needs. Currently he gets occupational, speech, and physical therapy which prevents him getting more spastic and more disabled. Insurance doesn't always cover this.

I am concerned whether he will be eligible for these therapies when he becomes an adult. He gets some of them as education-related services in school, but what happens when he turns 21? I believe that the States should be required to demonstrate that the range of services that they offer will be sufficient to meet the needs of eligible people with all types of disabilities and functional differences across the full spectrum of age.

While this is very important, there are other needs, too. I am concerned about portability. If I move, can I expect the same type of benefits in another State or jurisdiction? I urge you to review the recommendations that CCD has in this area.

Also with regard to coordination, will I get some assistance in coordinating the many aspects of Joshua's care or will somebody be available to help him when he is an adult to live a normal life?

Respite services must be included. If there is no personal assistance available, the need for respite care is even more paramount.

When Joshua lives as an adult and gets an apartment and tries to do all the other things that a young man does, who is going to provide the service coordination, the organization and protection that I now provide and will he end up in an institution because health care reform forgot to take into account his long-term needs? Who will ensure there is a replacement wheelchair when his is being repaired?

It is wrong to waste all the energy and investment that I, the education system, and others are putting into making him an independent and productive citizen if this were to occur.

I am rapidly burning out from the lack of long-term services and supports available now to Joshua and me. Please use this opportunity for reform to give families like mine a break and make sure that our national policy is supporting dignity and independence and not segregation and dependence.

I am not asking for a \$700 screwdriver to repair the wheelchair or a gold-plated walker to help Joshua get out the door. I am only asking for support and assistance for the long-term needs of my child and the thousands of other Joshs across the country and their families so he can live a quality life like an average child.

In addition, I would like to say that people with disabilities not only need good long-term supports but they need adequate and appropriate acute health care.

I would welcome the opportunity testify on that. The President has taken a good first step. I challenge you to take the rest.

Thank you.

Chairman STARK. Thank you very much. I appreciate you sharing your testimony and your concerns with us this morning, Ms. Simpson.

[The prepared statement and attachments follow:]

Consortium for Citizens with Disabilities

TESTIMONY RESPECTFULLY SUBMITTED

TO THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

November 2, 1993

Presented by Jenifer Simpson, Washington, D.C.
Parent of Joshua Chartienitz, Eight Years Old
Accompanied by Christina A. Metzler
American Occupational Therapy Association
Co-Chair of Long Term Services/Medicaid Task Force
of the Consortium for Citizens with Disabilities

On behalf of the
Consortium for Citizens with Disabilities
Task Forces on Long Term Services/Medicaid
and
Personal Assistance

ON BEHALF OF:

American Foundation for the Blind
American Association of University Affiliated Programs for Persons
with Developmental Disabilities
American Association on Mental Retardation
American Network of Community Options and Resources
American Occupational Therapy Association
American Psychological Association
Bazelon Center for Mental Health Law
Epilepsy Foundation of America
Federation of Families for Children's Mental Health
International Association of Psychosocial Rehabilitation Services
Learning Disabilities Association
NISH
National Association of Developmental Disabilities Councils
National Association of State Directors of Developmental Disabilities
Services
National Association of Rehabilitation Facilities
National Association of Protection and Advocacy Systems
National Consortium on Physical Education and Recreation for Individuals with
Disabilities
National Easter Seal Society
National Head Injury Foundation
National Mental Health Association
National Parent Network on Disabilities
The Accreditation Council on Services for People with Disabilities
The Arc
United Cerebral Palsy Associations, Inc.

INTRODUCTION

Mr. Chairman, Members of the Committee, I am Jenifer Simpson and I am here today to speak about long term support services for my eight year old son, Joshua, who has cerebral palsy. Josh is one of some 500,000-700,000 children and adults with cerebral palsy in the United States and among the more than 2 million persons with developmental disabilities--severe disabilities which occur early in childhood. These people constitute some of those children, young people and adults with disabilities who need long term supports. I am testifying today both as a parent of a child with severe disabilities and on behalf of the Consortium for Citizens with Disabilities (CCD).

As you may already know, the Consortium for Citizens with Disabilities (CCD) is a working coalition of over one hundred national consumer, service provider, parent and professional organizations that advocates on behalf of people with disabilities and their families. The work of the CCD is conducted by Task Forces in various policy areas such as health care, Social Security, education, employment, housing, civil rights, personal assistance and long term services. Christina Metzler who is with me today co-chairs the Task Force on Long Term Services/Medicaid.

Let me tell you about Joshua, what he needs and what our family needs.

Because Joshua needs a complex array of long term supports integrated with his needs for acute health care, I am pleased, as is CCD, that the President's plan does address long term care as an integral part of a comprehensive reform of the health care system. This integration is critical both for policy improvement and for the lives of people like Joshua. Long term services and supports are critical for Joshua, me and for many other people and families who experience severe physical disabilities. However, in designing a national long term services program, Congress must keep in mind that the causes and consequences of chronic disabilities are highly varied and require significantly different responses on the part of the service delivery system, depending on the nature and extent of the individual's disabling condition as well as the surrounding circumstances of his or her life. An adult with quadriplegia will require a much different constellation of services and supports than someone with needs similar to Joshua's. Likewise, a young adult with severe and persistent mental illness needs access to an array of continuing and intermittent supports that would be inappropriate in the case of an elderly individual who no longer is able to perform basic functions of daily living. Formulating an effective national long term service policy, therefore, must begin with an appreciation of the diversity of needs represented among the millions of Americans with severe disabilities and proceed to the creation of financing mechanisms and service delivery strategies that fully accommodate these differences.

PERSONAL SITUATION AND SYSTEMS ISSUES

I want to tell you what Joshua needs now and what he will need as an adult. This lifetime view about the needs of a child with disabilities is critical to me and for our society in approaching health care and long term services reform, for I won't always be around to see he gets what he needs.

In many ways, Joshua is a typical little boy. He likes computers and playing with toy trains, including watching "Thomas the Tank Engine." He's social, alert and attends school. Joshua went Trick or Treating last Sunday on Halloween dressed as a clown and was wheeled around by the neighborhood children who are his friends and took turns assisting him. He's skipping school today to be help me tell you our story so that you may better understand the experiences and struggles of the thousands of families around the country who face long term care needs every day.

What makes Josh different from most other kids, though, is his disability. Or, rather, our Nation's failure to fully support my decision and efforts to raise him at home, where he belongs. Cerebral palsy is not a disease or illness. Rather, it is a lifelong disability that can affect a person's ability to express themselves, and/or perform everyday activities independently that you or I do almost without thinking. Joshua's disability makes it difficult, if not impossible, for him to walk, talk, eat, drink, use the bathroom, get dressed, or do most anything without a lot of help. He gets much of that assistance from me. But, besides being a full time single Mom, I am also a full time Policy Associate with United Cerebral Palsy Associations' Governmental Activities Office here in Washington.

Increasingly, therefore, I must pay others to provide Joshua with the personal assistance he needs when I cannot be there to do it for him myself. Also, I won't always be around and less and less as I get older can I handle the stress of being a care provider and working a quadriplegia job that supports the both of us.

In this regard there are several important points in the Presidents proposal. First, Joshua would likely be eligible because he meets the test of limits in all five areas of Activities of Daily Living: eating, dressing, bathing, toileting, transferring, ; however, I am concerned as is CCD that many other children might not fit the criteria. Personal assistance services, that would help me care for Joshua's needs, would be available to me because they are mandated to be provided by the state. Our family could also qualify for this program even though I earn a middle income; we would not have to impoverish ourselves to become eligible for Medicaid, which is the major source of services now. These are very positive steps and would have a direct impact on me, improving our life and making good use of public resources.

But there are some concerns. I have been told to institutionalize my child several times by well-meaning professionals. I have discovered this would cost the taxpayers about \$80,000 a year to do, and Medicaid would then make him eligible, paying fully for that service. For one tenth of that cost I make sure he leads a normal life but I get no family support to assist me for doing this. I think that the cost for personal assistance, technology, respite, therapies, and other services Joshua and others like him need would be much less. And the important thing is this enables him to live a regular type of life--to go Trick or Treating with friends in his own neighborhood, to go to school, and ultimately to contribute to society as a taxpayer with supported employment opportunities. I am pleased that the President has understood this important issue and emphasized home and community services. But I am disappointed the proposed program will still allow for complete coverage of institutional care for families who cannot provide for their child any longer. This coupled with the cap on federal funds for the new program while nursing facilities and other institutional services will remain open-ended is not fair. This imbalance still leaves open the possibility that I or Joshua himself will at some time have no choice but an institution. I will not choose that now and I want to do everything in my power to change that bias so it does not threaten Joshua when he is an adult.

Currently, Joshua gets habilitation therapies such as Occupational, Speech and Physical Therapy. Our insurance does not always cover ongoing therapies. But these therapies are a critical need for him to stop him from becoming more disabled which is what happens if he goes without these critical habilitation therapy supports. They also help him to acquire and maintain important function. I am concerned about whether he will be eligible for all the therapies he needs now and when he becomes an adult. The President's acute health care proposal addresses therapies but they may be limited; in regard to long term services, therapies for habilitation and rehabilitation are only state options. I and CCD believe that states should be required to demonstrate in their state plan that the range of services that it will offer will be sufficient to meet the needs of eligible people with all types of disabilities and able to respond to significant functional differences across the full spectrum of ages. While personal assistance is important to me and many others, it is not all that Joshua needs.

Joshua also needs some specialized technological equipment like his augmentative communication device, a prone stander, prosthetic braces, special adaptations to the wheelchair and other critical technology-based items. He also needs frequent adjustments and changes to customize his wheelchair. I have gone through much aggravation and paperwork with several different health care insurers about getting these items, with varying degrees of success.

Other children with disabilities different than Joshua's might need other kinds of equipment to facilitate in-home care, such as a respirator or special feeding equipment. These can be the lifesavers that keep a child at home, not shunted away to some big facility, far from family and friends.

When Joshua as an adult lives in his own apartment, gets a job and tries to do all the other things a young man does, who is going to provide the service coordination? Will there be a service agency that helps him get training or supported employment? Will there be a replacement wheelchair made available to him when his regular one is in the shop for repair? Will he have a service coordinator who makes sure he has a real home and good doctors and that he gets and takes his medications? Will he have supports to get out into the community, to manage his money, to assist him to make whatever choices he

can? These "service coordination" jobs are mine now. I certainly hope that full implementation of a new long term services program would address these present and future problems.

This is our personal experience with long term services. Other individuals with different disabilities will have different service needs, hour requirements, and circumstances to contend with. A person with a cognitive disability might need several hours per week of assistance in managing their money and making financial decisions. In another instance, a person might need a reader, sign language interpreter, or oral interpreter to communicate with landlords, relatives, or shopkeepers. An individual with Alzheimer's disease may need other kinds of therapy or supports.

Some people with other long term support needs typically receive their services through a variety of specialized provider agencies. Many of these community providers serve individuals who are receiving Medicaid-reimbursable services. However, access to these services depends on the state you live in and your level of income and resources. Again, Medicaid services are limited to individuals with very low incomes who are among the most vulnerable. But I would prefer not to make myself more vulnerable by becoming poor just to receive services. As I said, I want to be productive and live my life as well as get what Josh needs.

Many people with disabilities are in jeopardy of being placed in a long term care institution, such as a nursing home, psychiatric treatment facility, or a residential center for people with developmental disabilities. The existing federal policy bias toward using institutional care when a person has a particular diagnosis or may need a high level of service must be reversed. I know I would never voluntarily choose this option and I hope he is never forced into this. It will likely depend on what is done now with long term services and health care reform.

VARYING LONG TERM SERVICE NEEDS: SOME EXAMPLES

The following are brief descriptions of various people with disabilities of all ages and the circumstances of their lives. Long term services reform as a part of the health reform package will be vitally important to them all.

o A ten year old boy in Connecticut who required 24-hour a day ventilator support lived in a hospital for the first three years of his life. With intensive respiratory interventions and exercise, he has been able to reach the point where he lives at home with his family, attends public school in the fifth grade, and requires ventilator support only at night while sleeping. Continued access to such support will be vital to him.

o A twenty-eight year old man lives in a nursing home in Virginia because he is unable to receive the combination of nursing services, personal assistance services, and companion services which he needs to remain in his home. As a result of multiple gunshot wounds, he is paralyzed from the neck down, requires a ventilator, and uses a motorized wheelchair controlled by a mouthstick. His marriage has ended and he is now able to see his two children, ages seven and four, in short visits spread over the year, totalling only about 48 hours a year. With proper personal assistance and other long term supports, he could live in his home community and participate more fully in the lives of his children.

o A young woman, age 24, with cerebral palsy and mental retardation has benefitted significantly from the Medicaid community supported living arrangements program. She lives in her own apartment with a roommate and counselor, has found a job, and pays taxes. She has formed new friendships and has increased her independence, access to the community, and her self esteem. Although she has made great progress, she will continue to need long term services and supports for the foreseeable future.

o A twenty-five year old man in Maryland who is diagnosed as having paranoid schizophrenia has spent many months in psychiatric hospitals over the last several years. Although his disability and numerous hospitalizations had a serious impact on his ability to participate in school, he eventually earned his diploma. Through a community outpatient psychiatric rehabilitation program, he receives numerous long term support services which are enabling him to become more independent in the community. He receives assistance in keeping his medications under control, learning to use public transportation, learning job seeking skills and appropriate business attire and behavior, managing money and paying bills, and is learning to live on his own. He will need continued support in various aspects of his life in order to maintain and

increase his ability to live independently and to avoid future hospitalization.

o A seventeen year old girl is experiencing major changes in her life as a result of traumatic brain injury during a car accident. She is having a slow recovery, is experiencing learning problems, frustration and extensive social changes, and attends school only half day while she receives rehabilitation services everyday. As she matures and as the extent of her injuries are revealed she will need various supports over time, including services to assist her in making the transition from school to work and to assist her to become as independent as possible within her community.

o In Wisconsin, a young boy born with cerebral palsy and sensory impairments requires a tracheostomy tube to help him breathe, a gastrointestinal tube to help him eat, and other extensive medical, health, and social supports. He lives at home with his family, attends his neighborhood school, and relies on a number of basic supports from numerous sources such as the school system, private insurance, Medicaid waiver services, and state and county community and respite care services programs. While managing services from many different sources is complicated, the mix enables him to live at home and to stay out of an institution. He will continue to need support at school, specialized therapies, prescription medications, special diets, personal assistance, adaptations such as a lift on the family van, and support for community living as he grows older.

CCD APPROACH

CCD has considered the development of a comprehensive long term services program to be a critical need area for many years. A comprehensive long term services program would include supported living services, personal assistance services, supported employment, assistive technology devices and services, and an array of community support services for people with disabilities.

CCD's Task Force on Long Term Services/Medicaid has been working on issues related to the long term service provisions of Medicaid, while other CCD Task Forces, such as Housing, Employment and Training, and the Technology Task Forces have been working on other aspects of this comprehensive service system. A relatively new Task Force on Personal Assistance Services was created in 1990 to address the critical personal assistance component of the system.

The CCD Personal Assistance Services Task Force includes representatives from across the disability community, including people with physical, cognitive and other mental impairments, including mental illness, and sensory impairments. Together we worked to refine the draft bill Personal Assistance for Independent Living originally produced by the World Institute on Disability.

CCD established working groups on crucial issues of system design; training and compensation; quality assurance; eligibility & services; and due process. The deliberation of these groups lead to the development of a concept paper, Recommended Federal Policy Directions on Personal Assistance Services for Americans with Disabilities, that sets forth the philosophies and principles that CCD believes any comprehensive personal assistance services program must meet. This document is included as Appendix 1.

CCD has met on an ongoing basis with the American Association of Retired Persons, the Long Term Care Campaign, the Older Women's League, the Alzheimer's Association, Families USA, and other groups representing elderly people to discuss and compare our long term care proposals with a view toward defining areas of consensus regarding long term services between the disability and aging communities. Ideas, views and opinions were exchanged among the groups through a number of meetings and forums. While there has not been total agreement in all areas, there was enough common ground among the groups to establish an ongoing dialogue and a working partnership. Together, CCD, AARP, and the Alzheimer's Association have presented consensus recommendations to the Administration Working Group on Long Term Services. This effort continues even now.

REACTION TO PRESIDENT CLINTON'S PROPOSAL

President Clinton's proposals on long term services have many strengths. He calls for a bold new commitment of \$65 billion over five years for services that are vitally need by people with significant disabilities. If I am able to leave you with only one message today, it would be this: It is absolutely

critical that long term services be included in the efforts to reform our national health care system. We must stress that ignoring long term services will short-change many people and limit the effectiveness of any reform.

There are many positive aspects to the President's plan and some points where the plan can be strengthened. CCD is committed to work together with the Congress and the Administration to ensure that the best possible reform program be enacted. The following comments are based on the September 7 draft and subsequent oral updates by Administration officials. When we have had an opportunity to thoroughly review and analyze specific legislative language, we will refine our comments.

A. STRENGTHS OF THE PRESIDENT'S PROPOSALS

There are many commendable components in the Clinton long term service proposal.

1. New Commitment to Long Term Services -- First and foremost is the President's willingness to commit new federal resources -- an estimated \$65 billion over the next five years -- to expanding and improving long term services that are desperately needed by Americans with significant disabilities. This commitment will enable thousands of people with disabilities to access education and training programs, hold jobs, and participate in community activities -- often for the first time in their lives.

2. Emphasis on Home and Community Services -- CCD is pleased with the Clinton Administration's emphasis on expanding access to home and community based services rather than institutionally based services. In general, home and community based services are more cost effective than institutional services and afford people with disabilities greater opportunities to become contributing members of society. The overwhelming desire of most people with disabilities is to remain in their own homes and communities, while receiving the support services necessary to remain as independent as possible.

3. Eligibility Criteria -- The President's plan takes a positive step forward in attempting to cover people of all ages with all types of disabilities -- cognitive, mental, and physical. Historically, other proposals have excluded people on the basis of one type of disability, such as mental illness; CCD considers that approach unacceptable. The proposal also allows eligibility for all income levels, thereby beginning to address the marriage penalties of the income-based programs and the problem of people having to impoverish themselves in order to have the assistance they need to survive and prosper. It also addresses the work disincentives issue, where people who are receiving needed services accept a job, lose their benefits, and yet do not earn enough money to meet their basic living needs and purchase their disability-related goods and services.

4. Basic Philosophies -- The disability community is delighted to see that the Clinton proposal contains many principles and philosophies that we believe must be a part of any long term services system if it is to be effective. These principles include a commitment to consumer directed services, an option for the use of vouchers or direct cash payments, consumer involvement in planning the state long term services program, and individualized service needs assessments and plans of services.

These directions are particularly important because of the changing nature of the entire disability services system and we applaud the Administration's recognition of them. Services for individuals with disabilities historically have been delivered in a paternalistic manner. In light of the promise of empowerment implicit in the American with Disabilities Act, people with disabilities now expect to exercise an increasing degree of control over their lives, their rehabilitation and their support systems. Involvement in the design, direction, management, and assessment of their individual support services enables people with disabilities to exercise a degree of control over their own lives that is essential to physical and emotional well-being.

The ability of people with disabilities to participate actively at the planning level of long term services means that there will be a greater chance that the service system ultimately will meet the needs of those it is intended to serve. Given the number of jobs that will be created by a new \$65 billion program over five years, this program represents an unique opportunity to employ some of the persons with disabilities in America (67 percent of whom

are not working) through their participation in policymaking, administration, management, and direct service jobs that will be created.

5. **Tax Credits** -- The proposed tax credits will help to offset the extraordinary expenses of living with a disability and assist people with disabilities to enter the workforce by giving them a measure of economic equity with those who do not need to pay these extraordinary costs.

6. **A Good First Step** -- CCD believes that the President's long term services plan represents a significant beginning for a system that should ultimately be comprehensive. While it is desirable to make long term services available right away to all individuals with disabilities who need them, CCD recognizes that fiscal restraints will necessitate the gradual phasing in of coverage in some orderly fashion. We are concerned about phasing in this coverage in an equitable manner so that people with varying types of disabilities and economic circumstances will be treated fairly and in a manner to ensure that their needs are appropriately met.

8. ISSUES TO BE ADDRESSED IN THE CLINTON PLAN

In the previous section, I have described the numerous positive aspects of the President's proposal for long term services reform and, in particular, those areas which reflect the principles and philosophies which the disability community believes must be included in any true reform of long term services. In this section, I want to draw your attention to various issues that CCD has identified which raise serious concerns about the effect of the proposal on people with disabilities. We believe that these are not insurmountable obstacles and we look forward to working with the Committee and the Administration to resolve these and other issues.

1. **Eligibility Criteria** -- The eligibility criteria contained in the proposal are too limited in several ways. Taken as a whole, the criteria would not cover many people who clearly need long term services. The President's principle of universal coverage would not apply to long term services where eligibility is so limited. Concerns regarding the specific criteria are as follows.

According to the Administration's own estimates, only about 25 percent of the people who need long term services and supports will be eligible to receive them under the proposed new, universal home and community-based funding authority. The use of the "3 out of 5 activities of daily living (ADLs)" test will leave many people with substantial service needs without coverage.

The Administration-proposed equivalency criteria applicable to people with cognitive and mental impairments are flawed and would extend eligibility to only a small percent of people who need long term services. As an example, the criteria for mental retardation would cover people with what was formerly known as "severe or profound mental retardation" (with I.Q.s below 36). Those categories include only about 5 percent of individuals with mental retardation and exclude many people whose disabilities are severe enough to qualify them for Supplemental Security Income on the basis of I.Q. alone. Although people with mental retardation might qualify under the other eligibility criteria, we anticipate that tens of thousands of people whose mental retardation, while not "severe" or "profound," nevertheless constitutes a very severe disability, would not qualify for this program since the ADLs are more targeted to the needs of people with physical disabilities.

Further, the use of I.Q. as a sole determinant of functional ability is outmoded and unacceptable. The use of I.Q. as a sole eligibility criteria does not reflect best or current thinking in the field of developmental disabilities. Indeed, the community representing people with mental retardation has moved beyond the mere classification of people by test score, which historically has perpetuated negative and stereotypic attitudes about persons with significant disabilities, to viewing the circumstances and competencies of the person holistically. A new definition of mental retardation, recently adopted by the American Association on Mental Retardation (AAMR), reflects this more positive, updated approach to assessment. AAMR's definition is attached as Appendix 2.

In addition, the criteria for people with severe cognitive or mental impairments should not be predicated on criteria that is used for commitment to an institutional setting -- i.e., "the applicant poses significant danger to self or others." A severe mental illness is characterized by episodic or persistent symptomatology. Successful community support programs have evolved

to prevent or compensate for symptoms associated with acute episodes and to decrease utilization of institutional care by providing seamless access to services that include rehabilitation and assistance in other areas such as: nutritional needs, including purchasing, storing, and preparing food; taking medications; and budgeting for food, clothing, and shelter. Similar services are often critical to people with cognitive impairments as well. The standard mental status exam which is being proposed by the Clinton Administration has yet to be developed and validated. We want to ensure that people with serious cognitive or mental impairments who require extensive ongoing services and supports are not excluded by the use of any new instrument.

Finally, the criteria for use with children is far too limited. It would cover only children under age six who are dependent on technology and who would otherwise require hospital or institutional care. This standard would, once again, use institutional need as the yardstick for eligibility, thereby furthering the institutional bias which already permeates the Medicaid program. The need for and availability of home and community services should not be benchmarked against institutional admissions criteria in the case of either children or adults. Further, the requirement that the child also be technology dependent is severely limiting and is likely to leave children with equivalent disabilities who do not depend on respirators or other technological devices without the home based support that they need. Finally, it is not clear what happens to children over age six who otherwise meet the children's criteria and to children of any age who might qualify under one of the other criteria. Are criteria that are standardized on the adult population to be used in establishing the eligibility of children over six years of age?

CCD had submitted to the Administration proposed criteria which would attempt to reach people who do not meet the ADL and other tests yet have disabilities at levels equivalent to the 3 ADL criteria. Such criteria would give the Secretary flexibility in assessing other circumstances and factors for eligibility as needed. In addition, CCD's proposed criteria would have used the SSI functional approach (for evaluating disability only) for all children from birth to 18 years of age, that is: inability to function independently, appropriately, and/or effectively in an age-appropriate manner. We urge reconsideration of this feature of the Clinton proposal and attach suggested substitute criteria as Appendix 3.

CCD believes it is important to note that, although the eligibility criteria are flawed, the proposal reflects an understanding of the need to use different approaches for determining eligibility for people with differing disabilities. This is within the expressed intent of covering people with all types of disabilities, regardless of diagnosis.

2. Scope of the Basic Service Package -- There are two issues which must be addressed regarding services to be covered under the new home and community long term services program. One is the breadth of the service package and the other is the definition of personal assistance services itself.

a. Scope of the Basic Service Package -- Regardless of the ultimate definition of personal assistance (discussed below), the proposed program must recognize that personal assistance services is only one element of the array of long term services and supports required by people with severe disabilities.

As I stressed earlier in my testimony, severe disabling conditions occur in many forms and, thus, a broad array of services and supports must be available to appropriately address the needs of all eligible participants. There is a real danger that many eligible individuals -- especially people with significant mental and cognitive disabilities or multiple disabilities -- will be denied the full range and intensity of community services they need if this new federal funding authority is narrowly construed by the states. Given the fact that federal funding levels would be capped and the states granted broad discretion in determining the range of services to be provided (i.e., other than personal assistance services), we believe that this is a possibility which should be seriously considered.

CCD believes that the services which are considered to be state options under the President's proposal optional should, in fact, be part of the basic service coverage in each state, in addition to personal assistance services. As stated in the proposal, these services include "any other community based long term care services including: case management, homemaker and chore assistance, home modifications, respite services, assistive technology, adult

day services, habilitation and rehabilitation, supported employment and home health services not otherwise covered under Medicare, private insurance or through the basic health plan."

In addition, states should be required to demonstrate in their state plans that the range of services that it will offer will be sufficient to meet the needs of all eligible people regardless of the type of disability they have, their age or the level of complexity posed by their disabling condition. In preventing the furtherance of the use of institutions, it is important that people have access to a full range of needed services and that they not be forced to accept institutional services for lack of adequate and appropriate home and community services. Costs should not be an issue in making these changes since the level of federal financial participation is capped. CCD's recommendations would, however, assure that people with disabilities will be eligible for similar services no matter where they live thus ensuring interstate "portability" of long term services and supports and that they will not be subject to the vagaries of state-level political decision making regarding vital services which they require through this joint federal/state program.

b. Definition of Personal Assistance Services -- In the Clinton plan, personal assistance services for the new home and community services program are defined as "assistance (including supervision, standby assistance, and cuing) with activities of daily living". CCD believes that the inclusion of supervision, standby assistance, and cuing is important and should remain in the definition.

However, CCD is concerned that the definition is limited to activities of daily living. This aspect of the definition will make the services useful primarily to people with physical impairments who meet the ADL test and will not address the personal assistance needs of people with mental or cognitive impairments who are otherwise eligible. CCD recommends a broad definition of personal assistance services which would include the services needed by people with cognitive and other mental impairments and sensory impairments. This definition can be found in the paper Recommended Federal Policy Directions on Personal Assistance Services for Americans with Disabilities in Appendix 1. Again, broadening the definition to include essentially any services which will assist the functioning of an individual should not affect the cost of the proposal since the home and community services program is capped. Broadening the definition will, however, allow the states to be flexible in meeting the needs of all eligible people in the program. We note that the Administration's September 7 description of its long term care proposal included a much broader definition of personal assistance services in the section dealing with the tax credit.

The proposal makes a distinction between agency-administered and consumer-directed services. We note that, while consumer-directed or voucher programs may be the purest form of consumer control, even agency-run services can be designed to be consumer-directed in many respects.

3. Medicaid Long Term Services for People with Low Incomes -- As stated earlier, this analysis is based upon the contents of the September 7 draft and subsequent oral updates by Administration officials to representatives of the disability community. Central to our analysis is the understanding that the September 7 Clinton Administration's proposed low income home and community services program will be eliminated and that, instead, the Medicaid program will continue to provide both institutional home and community long term services to people who are eligible for Medicaid. Given the fact that the new eligibility criteria for the Administration's new long term services program is much more limited than the current eligibility criteria for Medicaid long term services, the continuation of community based services through Medicaid is absolutely essential to meet the needs of people who are now eligible for Medicaid as well as people who may become eligible for Medicaid in the future. For example, under the Medicaid optional programs now available to people with serious mental illnesses (targeted case management, clinic services, and rehabilitation services), innovative long term services have reduced unnecessary or prolonged institutional care, homelessness (which can be prevented or ameliorated with assertive community treatments when not restricted by arbitrary limitations) and inappropriate incarceration of adults when there are no other places of treatment or supports because of inadequate funding in the health care system.

CCD believes that it is necessary to continue to make improvements to the Medicaid long term services programs so that they will better reflect state of the art approaches in serving people with disabilities. Such improvements are

needed in: the home and community based waiver program (including the expansion of the definition of habilitation services to include supported employment for all waiver recipients), making the community supported living arrangements services program a coverage option under all state Medicaid plans, eliminating the discriminatory treatment of low income people with mental illness under the Section 1929 home and community-based state plan coverage option, the Intermediate Care Facilities for the Mentally Retarded (ICF/MR) option, and improving administration and regulation of OBRA 1990 PASARR requirements regarding inappropriate nursing facility admissions. CCD has previously submitted to Congress specific proposals for dealing with each of these limitations in current Medicaid policy; and, I would stress, none of them have been shown to cause a significant increase in federal-state Medicaid spending.

It should also be noted that most current Medicaid long term services are optional to the states. In conjunction with the differential federal match available to states for services under the new home and community program (expected to be significantly higher than the match for the remaining Medicaid program), there is significant fear that states will divert existing Medicaid matching dollars that currently are being used to furnish community services to low income people who need them but who would be ineligible under the new program's stricter eligibility criteria. This potential situation raises serious issues of long term security for individuals and their families and must be addressed in any forthcoming legislation.

4. Consumer Involvement -- As discussed above, the Administration proposal rightly includes a new focus on consumer involvement in various aspects of the state plan. CCD believes that this positive direction should be enhanced with greater attention to consumer involvement in state planning and program design, and in quality assessment of the services and supports and the system through which they are provided. CCD submitted extensive consumer participation recommendations to the Administration earlier this year. These recommendations, which would enhance the role of consumers and their representatives at the policy and implementation levels, are attached as Appendix 4.

In addition, it is crucial that the proposed Medicaid Commission, which we understand is to be appointed to determine the future of Medicaid acute and long term services, have adequate representation and input from all areas of the disability community. As major consumers of Medicaid acute and long term services, the disability community must be heard and must be a full participant in efforts to develop the Commission's recommendations.

5. Institutional Bias -- The current Medicaid program contains clearly recognized institutional biases which CCD believes should be eliminated and thus should not be carried forward into or exacerbated by any new community services authorities. In fact, it is our hope that the creation of a new community based long term services program would reverse these current biases. However, there are some features of the proposal which we believe threaten to establish new biases in favor of institutions. They include: establishing a cap on expenditures for the new community based services program while the nursing facilities and ICFs/MR remain uncapped; new mandates for medically needy spend-down programs for institutional services but not for community services; and proposed increases in the resource limits and personal needs allowance, which are sorely needed but which are targeted only to people living in institutions without comparable income and resource protections for people living in the community. [The (previously mentioned) low income proposal contained features which many believe would have further exacerbated the institutional biases of the Medicaid program. We believe that these features were completely unacceptable; we will not dwell on them here as they appear to have been reworked.] We urge Congress to be vigilant about truly promoting community services.

6. Equity in Co-Payments -- As in the acute portion of the plan, CCD believes that more work is needed on the co-payment sliding scale. The amount an individual or family (with a member living at home) is required to pay should also be capped, based on a percentage of income. Otherwise, the current co-payment structure may make home and community long term services exorbitantly expensive for people with low incomes. Particularly since people with higher incomes will be eligible for services, it is imperative that the costs of services not be out of reach of low and middle income individuals and families. This would be especially true of individuals with high service needs and costs. Is it fair that a family of four with a net taxable income of \$24,000/year which is supporting a ventilator-dependent child at home, whose costs total \$85,000, should pay fully 10 percent of the cost with no

cap, while they would incur no costs if the child were institutionalized in a Medicaid certified long term care facility? Similarly, should not a couple with net income of \$125,000/year and community services costs of \$8,000 be required to pay more than \$3,200 per year?

Further, it is unclear what impact the tax credit will have on low and high income people in relation to their co-payment costs and whether the tax credit is available for working families with children and other members with disabilities. In addition, there is great concern within the disability community with the proposed prohibition against allowing states to use income as a basis for allocating resources during the phase-in, since this will prevent states from targeting resources to those most in need.

7. Children -- Special attention must be paid to the effects of the proposal on children. Children who lose Medicaid coverage because they are covered by the alliance health plans would lose their access to important therapy and other long term services and the protections of the Medicaid Early and Periodic, Screening, Diagnosis, and Treatment program (EPSDT). Forcing these children to go without cost-effective extended services is unacceptable. The failure to fully cover these vital services also jeopardizes early intervention and education-related services under Part H and Part B of the Individuals with Disabilities Education Act by withdrawing a major funding source at a key time during implementation. This would be especially important for infants, toddlers and children who do not meet the eligibility test for the new program.

8. Payment Rates -- Payment rates for providers must be high enough to enable them to cover legally required employee benefit payments such as Social Security, Medicare, tax withholding, and the new employer-mandated health insurance premiums. This is particularly an issue in voucher and cash payment situations where the individual with a disability directly hires his/her personal assistants. Experience in several states has shown that people either have to go without essential services or they get the services by paying below legally required minimum wages and benefits.

9. Other Issues -- There are numerous other critical issues which will need to be addressed in ensuring that the proposal can meet the needs of people with disabilities. These include: the need to address psychiatric services required over time which are beyond those covered by the basic benefits package; the need to resolve issues regarding state medical practice and nurse practice acts in relation to health-related tasks performed by personal assistance providers such as medication administration and catheterization; the relationship between acute health services and long term services for people with disabilities including clarification of treatment of services such as "outpatient" rehabilitation services which might be considered acute or long term services; an assessment of the impact of the state option for making capitated payments to health plans or other providers for community based long term services; and the length of time until full implementation of the long term services proposal. The relationship between acute health and long term services is problematic for all people with serious and persistent physical, cognitive, and mental disabilities; for people with psychiatric disabilities, there is the additional question of the linkage to essential long term services for people who exceed limitations for non-residential intensive services until the year 2001 when full coverage is scheduled to be in effect.

Again, CCD looks forward to working with this and other Committees of the Congress to address President's long term services proposal. We believe that long term services are a critical component of health reform and that the President has made a significant and important commitment and step forward with the proposal of a new home and community long term services program to serve people with disabilities of all ages without requiring impoverishment for eligibility. We urge Congressional support of this commitment and for including a strong long term services component in legislation to restructure the American health care system. We pledge to work with you to ensure the availability, appropriateness and effectiveness of such supports for all people with disabilities.

Consortium for Citizens with Disabilities

Appendix 1

DRAFT POSITION PAPER

Recommended Federal Policy Directions on PERSONAL ASSISTANCE SERVICES FOR AMERICANS WITH DISABILITIES

November 4, 1992
Task Force on Personal Assistance Services

INTRODUCTION:

The Consortium for Citizens with Disabilities (CCD) is a working coalition of over 70 national disability groups. At its 1991 Annual Meeting in January, CCD established a Task Force on Personal Assistance Services (PAS). The Task Force's charge has been to develop recommendations for crafting comprehensive federal legislation to promote expanded and more equitable access to a full array of lifelong personal assistance services for Americans with disabilities of all ages.

WHAT IS PERSONAL ASSISTANCE?

Personal assistance is defined as one or more persons assisting another person with tasks which that individual would typically do if they did not have a disability. This includes assistance with such tasks as dressing, bathing, getting in and out of bed or one's wheelchair, toileting (including bowel, bladder and catheter assistance), eating (including feeding), cooking, cleaning house, and on-the-job support. It also includes assistance from another person with cognitive tasks like handling money and planning one's day or fostering communication access through interpreting and reading services.

THE NEXT CHALLENGE:

CCD and other disability organizations view the passage of comprehensive federal personal assistance services legislation as essential to realizing the full promise of the Americans with Disabilities Act (ADA). The ADA extends full federal civil rights protections in the private and public sectors in employment, transportation, public accommodations and communication to all of the Nation's 43 million citizens with disabilities. In doing so, in President George Bush's words, it is meant to "bring the shameful wall of exclusion tumbling down." For many, this wall will not fall on its own accord, however. An estimated 9 million Americans with varying disabilities require access to an comprehensive array of personal assistance services in order to truly make the promise of ADA a reality in their every day lives. This paper will present the Task Force on Personal Assistance Services' major findings and recommendations for developing comprehensive federal legislation to ensure greater, more equitable access to personal assistance services for Americans with disabilities throughout our Nation. Specifically, it will outline what the components of such legislation should be in regard to its eligibility, services, individual service planning, training, compensation, quality assurance, rights protection/due process and system design requirements. The Task Force expects to develop and disseminate a second position paper on preferred means for financing personal assistance services.

WHO SHOULD BE ELIGIBLE?

Any child or adult should be eligible for PAS who:

- (a) has a permanent or temporary physical, sensory, cognitive or mental impairment;
- (b) has an impairment which substantially limits one or more major life activities; and
- (c) requires personal assistance services as defined in the legislation.

The term "major life activities" should be defined to include every day tasks such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, remembering, concentrating, reasoning, information and stimulus processing, understanding, and working.

INCOME:

Individuals who meet the criteria set out above should be eligible for personal assistance services under this legislation regardless of their income. Any child or adult eligible for PAS whose income falls below 300% of poverty should receive such services at no cost. States may wish to charge eligible persons whose incomes exceed 300% of poverty for some portion of the services they receive based on a sliding scale. However, no eligible individual should pay more than 2% of their net income, after disability related expenses are deducted, on personal assistance services funded under this legislation. Additionally, no resource test should be applied to the nonincome assets or marital status of eligible individuals. Children under 18 years of age should be eligible for PAS on the basis of their own incomes and not the incomes of their parents. Cost-sharing requirements should be based on income adjusted for out-of-pocket disability related expenses.

PERSONAL ASSISTANCE SERVICES GUIDING PRINCIPLES:

A wide variety of personal assistance services should be made available to eligible individuals under a federal PAS statute.

Such services should be designed to:

- * be guided and directed by the choices, preferences and expressed interests and desires of the individual;
- * increase the individual's "control over one's life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities" (as called for in the National Council on Disabilities' Policy for Persons with Disabilities, 1983);
- * enable PAS users to select, direct and employ their own paid personal assistants, if desired;

- * enable PAS users to contract with an agency for these services, if desired;
- * foster the increased independence, productivity and integration of the individual into the community;
- * be easily accessible and readily available to all eligible persons where and when desired and needed;
- * meet individual needs irrespective of labels;
- * allow payment to family members for the extraordinary¹ personal assistance they provide;
- * be provided in any setting, including in or out of the person's home;
- * be based on an individual services plan; and,
- * offer PAS users of all ages the opportunity and support needed to assume greater freedom, responsibility, and choice throughout life.

WHAT PERSONAL ASSISTANCE SERVICES SHOULD BE MADE AVAILABLE?

Personal Assistance Services funded under any comprehensive federal PAS legislation should include:

1. **PERSONAL SERVICES** including, but not limited to, those appropriate for carrying out activities of daily living in or out of the home including, but not limited to, assistance with bathing and personal hygiene, bowel and bladder care (including catheterization), dressing and grooming, lifting and transferring, eating (including feeding), giving medications and injections, menstrual care, operating and maintaining respiratory equipment and the provision of assistive technology devices and services;
2. **HOUSEHOLD SERVICES**, including, but not limited to, assistance with meal planning and preparation, shopping, light housekeeping, laundry, heavy cleaning, yardwork, repairs and maintenance;
3. **CHILD AND INFANT CARE ASSISTANCE** for eligible persons with disabilities who are the parents of children under the age of 18 meant to assist them in carrying out the functions of parenting at times when they would typically do so if they did not have a disability (e.g., assistance with diapering, feeding, lifting or transporting a child);

¹extraordinary personal assistance services will be clarified in report language. That language will define these services to be those that are above/ and beyond the tasks that family members would perform for each other under ordinary circumstances. Criteria will be developed to define above and beyond. Finally, we will try to give an example of what we mean using a kid.

4. **LIFE SKILLS SUPPORT SERVICES**, including, but not limited to, assistance with money management, planning and decision making including computer assisted directions, home management, use of medications, following instructions, positive behavior management, companion or roommate services which provide regular supervision up to 24 hours for daily living, peer support, advocacy, and support for participation in social, community or other activities. Life Skills Support Services assist the individual to acquire, retain, regain, improve, or execute the self-help, socialization, decisionmaking, and adaptive skills necessary to achieve and maintain independence, productivity and integration and to live successfully in his/her home. These services can include training, prompting, cuing, support or substitute functioning;
5. **COMMUNICATION SERVICES** including, but not limited to, assistance with interpreting, reading, letter writing and the use of communication devices, augmentative communication devices and/or telecommunication devices;
6. **SECURITY-ENHANCING SERVICES**, including, but not limited to, monitoring alarms or systems and making or arranging for periodic contact in person and/or by telephone;
7. **MOBILITY SERVICES IN AND OUT OF HOME**, including, but not limited to, escort and driving, mobility assistance including on the use of public transportation;
8. **WORK-RELATED SUPPORT SERVICES** including, but not limited to, ongoing services to assist an individual in performing work-related functions necessary to obtain and retain work in an integrated work setting, and to fulfill the functions of a job and personal services on the job;
9. **SERVICE COORDINATION** including assistance with recruiting, screening, referring and managing personal assistants;
10. **ASSISTIVE TECHNOLOGY SERVICES**, including assistance with evaluating the needs of an individual in his or her every day environment; purchasing, leasing or obtaining assistive technology devices for use by individuals with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing such devices; coordinating and using other therapies, interventions or services with AT devices (e.g., those associated with existing education/rehabilitation plans or programs); training or technical assistance for an individual with disabilities or where appropriate the family; and training or technical assistance for personal assistants; and
11. **EMERGENCY SERVICES**, including substitute or back-up services for any of the above services needed on an emergency basis. Back up or substitute services shall be made available when usual PAS providers are unable to provide the service.

12. EDUCATION SERVICES, children and adults with disabilities needing PAS shall be offered such services as part of their right to inclusive education as well. Such education and PAS shall include age appropriate opportunities to learn to use and control PAS effectively.

Such services would be provided in addition to any other services to which the individual is entitled under the Rehabilitation Act, the Individuals with Disabilities Education Act, Title III of the Older Americans Act, Titles V, XVIII, XIX, and XX of the Social Security Act or other public programs or private insurance.

INDIVIDUAL SERVICE PLAN

An Individual Service Plan (ISP) should be developed in conjunction with each user of personal assistance services funded in whole or part under a federal PAS statute. To the maximum extent possible, each ISP should be based on the individual's self-assessment of their needs or that of their legally appointed representative and/or advocate.

The Single Point of Entry shall be responsible for:

- making an eligibility determination based on the individual's self-assessment or other user friendly assessments; and,
- working with the PAS user and/or their legally appointed representative and/or advocate to prepare a mutually agreed upon written ISP based on these assessments.

At a minimum, the ISP should identify and describe:

- the personal assistance services' needs of the user, including the extraordinary personal assistant needs of a child or minor with a disability;
- the type(s) and frequency of the personal assistance services which will be provided to the user under the PAS Program;
- the type and frequency of the services which will be provided to the user by alternate resources;
- the type(s) and frequency of needed personal assistance services which will not be provided to the user through any means (i.e., unmet needs);
- the timelines for providing PAS to the individual;
- the qualifications and/or skills required by a personal assistant to perform the services;
- to what extent the user is capable of, or willing to, assume responsibility for managing/coordinating their own services and what type of management training, if any, should be provided to assist the PAS user or their legally appointed representative and/or advocate to do so;

- the current PAS arrangements and protect by grandfather clause those relationships declared to be satisfactory by the PAS user with reasonable and periodic adjustments in hours, wages and benefits;
- the outcome-based measures of performance on which the quality of the service(s) will be evaluated, and
- the type and frequency of the quality assurance steps to be taken to ensure the effectiveness of the service(s) and the user's continued satisfaction with the service(s) and the personal assistant.

The ISP should be developed through a highly interactive process involving the PAS user and/or their legally appointed representative, and/or an advocate selected by the user and/or their legally appointed representative, the service provider(s), and the service coordinator. The PAS user may elect to be the service coordinator. The knowledge, life experiences, views and desires of the PAS user or their legally appointed representative, and/or advocate should be actively solicited and given full consideration throughout the assessment and ISP process.

When necessary, the ISP should be coordinated with other service plans such as the IFSP and IWRP. All efforts must be made to protect the confidentiality and privacy rights of PAS users.

The ISP should be reviewed and updated at least annually in an efficient, non-obtrusive, and economic manner, or at the request of the individual or their legally appointed representative, and/or advocate to reflect the needs of the PAS user. When circumstances require, the ISP shall be amended so that additional services shall be provided to address the changing needs of the user.(e.g. injury, exacerbation of disability, illness or death of family member who provided PAS.) Disagreements arising from negotiations in the ISP development process should be resolved according to procedures described in the section on due process. PAS services should continue during any appeals.

STATE PLANNING AND PAS SYSTEMS DESIGN

Based upon the key concepts, principles and assumptions described in this paper, the minimum State planning and PAS systems design requirements should be as follows:

Lead State Agency:

A lead state agency should be designated by the governor or legislature to plan, develop, administer and coordinate and to accept full accountability of PAS programs, services and activities in each State. The legislation should make clear that this agency cannot be a medical/health agency. The responsibilities of the lead state agency should include:

- designating a single point of entry (SPE) in communities;
- maintaining a statewide (V/TDD) 1-800 PAS INFO Line to provide up-to-date data information on PAS services and refer individuals to the SPE and other resources in their communities;
- establishing procedures for program operations, including a process to enable funds to go directly to PAS users to hire their own personal assistants;
- creating incentives for private sector involvement, such as:
 - o comparable pay and benefits, unless state can justify otherwise
 - o preference for private providers which are user controlled;
 - o assistance to small private providers (e.g., in pooling to negotiate for goods and benefits);
- assuring uniform availability of PAS services throughout the state;
- preparing, in cooperation with the planning and advisory board, the State plan; and,
- establishing management assistance programs through contracts or other mechanisms to process FICA, tax withholding and other deductions of personal assistants.

Funds should be made available to pay for the agency's administrative costs associated with carrying out these and other related responsibilities.

Single Point of Entry:

The lead state agency should be able to designate/contract out with other public or private agencies to carry out the functions of a Single Point of Entry for PAS by 1) catchment area, 2) set population(s) and/or 3) set services.

To be designated by the state as a Single Point of Entry for applying for and accessing personal assistance services, an agency should be required to demonstrate the capacity and accept the responsibility to serve all those who need such services as well as to respond to multiple points of referrals.

Specific functions of the entry point would include:

- o intake
- o eligibility determination
- o conducting needs assessment/ service specificity
- o determining scope of services (hours, duration, etc.)
- o referral to providers
- o contracting for services
- o outreach initiatives, particularly to potentially eligible individuals

Such agencies also must be involved in interagency coordination, quality assurance, due process and all other aspects of PAS service delivery.

In order to be designated the single point of entry, an agency shall have a consumer controlled advisory council to guide it's activities and services. This council should be composed of 50%+ of PAS users and their families or representatives and broadly representative of the disability community.

Systems Change Incentives

The legislation should require that each State establish a state policy board on personal assistance services, which should be:

- o composed of at least 60% of PAS users and their families or representatives (2/3 are PAS users adn families or minor children, 1/3 are families or representatives or individuals not represented above)
- o broadly representative of the disability community
- o geographically representative
- o include members from affected state and local agencies
- o appointed by governor, with advice/nominations from the disability community
- o independent of the lead agency

The policy board should jointly develop the state plan with the state agency, and oversee implementation as well. It should be a staffed body and preference should be given to the hiring of qualified (cross disability trained) users of personal assistance services. Additionally, non-governmental members of the board who are not otherwise paid to perform duties associated with the board, should be reimbursed on a per diem basis. The per diem should include the salary, travel and other expenses of the member and those of their personal assistant(s) if applicable.

The PAS policy board also should take the lead role, in cooperation with the single state agency, in developing user-friendly policies that:

- o ensure widespread cross disability outreach and involvement in all aspects of the design, delivery and evaluation of PAS programs, services and activities, including training, throughout the State
- o create and require the use of user satisfaction standards and life outcome measures in all aspects of the State's PAS Quality Assurance efforts
- o prohibit the denial of services based on an applicant or PAS user's type or level of disability
- o promote cost-effective administration and other cost savings in the design, delivery and evaluation of PAS services
- o foster decision-making by PAS users in the design and delivery of PAS services
- o create and foster the use of a PAS conflict resolution process
- o promote the pooling of purchased goods and benefits
- o maximize private sector utilization

- o create, foster and assess the use of a direct subsidy option to provide PAS users the choice of purchasing their personal assistance services directly
- o eliminate or reduce the need for segregated, facility based care
- o require outreach efforts by Single Point of Entry agencies to ICF/MR's and nursing home facilities to ascertain need/availability of personal assistance services throughout the State

The PAS legislation should authorize the use of higher federal matching share as an incentive to eliminate or reduce the use of segregated, facility based care and instead provide individuals in segregated facilities with needed personal assistance services in their own homes and communities. The legislation should consider size of the institution and length of stay in regards to this provision. It also should require that each State PAS planning and advisory board hold a minimum number of meetings per year at a variety of convenient and accessible sites throughout the State.

Public participation, especially by PAS users and their families or representatives, in the workings of the board is essential. It should, therefore, be widely encouraged and a required part of each board meeting. Adequate public notice should be given for each meeting in a variety of accessible formats.

State Planning

The PAS legislation should require that each state develop a consumer-driven long-range 5 year plan, updated annually, on all aspects of the design, delivery, evaluation and future directions of PAS programs, services and activities in the State.

The single state agency should be responsible for preparing the State plan. Each state plan shall specify the timelines for it's implementation. The public, particularly PAS users and their families, must be involved in the development and revision of the plan. Feedback from quality assessment and consumer satisfaction assurance activities must be used in revising the plan annually.

Each plan should clearly describe and provide adequate assurances that the State has the sufficient capacity, user-friendly policies and practices in place to ensure uniform availability of PAS services throughout the state by providing for:

- o individualised services
- o cross disability coverage
- o life span coverage
- o statewide coverage
- o recruitment, referral, outreach and training systems
- o staffing and staff training
- o public participation
- o quality assurance

Each State plan should specify how funds may be spent and further delineate lines of responsibilities regarding all aspects of the design, delivery and evaluation of PAS programs, services and activities.

TRAINING ON PERSONAL ASSISTANCE:

Under a comprehensive federal Personal Assistance Services statute, Federal financial assistance for PAS skills training should be made available by the State lead agency. PAS users, and where appropriate, their legally appointed representatives and advocates should be informed of, and provided such value- and competency-based training on PAS upon request. PAS users, their families and advocates should be involved in every aspect of training, including the design of the training curriculum, training materials, and the delivery of training. The policy board should review these training programs.

Towards this end, States should provide assurances that, to the maximum extent possible, all such training is:

- reflective of and responsive to the preferences and expressed interests of individuals with disabilities;
- developed, designed, delivered and evaluated by qualified PAS users; and,
- provided by disability consumer organizations and other qualified agencies.

TRAINING FOR USERS OF PERSONAL ASSISTANCE SERVICES:

States should make available to each PAS user training in their roles, responsibilities, and rights as a manager and/or consumer of personal assistance services. The need for training should be described in and carried out as part of the user's Individualized Service Plan.

The training shall be provided in the primary language of the user. All materials shall be provided in an accessible format when needed.

Specifically, PAS management training should be made available to users to assist them to acquire and improve their skills in regards to scheduling, training, supervising, compensating, evaluating, disciplining, and discharging PAS workers. Similarly training also should be made available to users in quality assurance to assist them in defining quality life and service outcomes, evaluating the quality of the services, recognizing inappropriate and poor quality services, including neglect and abuse, and how to use the appeals process. All such training should be provided in the media, language, materials, and format which is best suited to meet the consumer's needs. A PAS user may waive their right to receive such training.

If an adult PAS user cannot fully benefit from this trainings or the user so directs, his/her legally appointed representative(s) and advocate(s) should be informed of and provided training upon request. When a child requires PAS, the personal assistant should be responsible to the parent/guardian until the child reaches the age of majority. Such parents should be informed of and provided upon request, training designed to assist the child, with his/her assistant, to assume increased freedom, responsibility, and choice as s/he grows.

TRAINING FOR INDIVIDUALS WHO PROVIDE PERSONAL ASSISTANCE:

An introductory orientation to PAS should be required for all individuals who provide personal assistance unless waived by the individual with a disability or the individuals who provides personal assistance has demonstrated experience. The orientation should emphasize to the individual who provides personal assistance that their purpose is to assist an individual with a disability to achieve self-determined goals.

This orientation for individuals who provide personal assistance should be value-based and include information on:

- disability as a natural human condition;
- the philosophy of independent living;
- the principles of community integration;
- the dignity of risk;
- the role, rights, and responsibilities of PAS users;
- the role, rights, and responsibilities of personal assistants; and,
- the appeals process.

The training and orientation shall be provided in the primary language of the provider. All materials shall be provided in an accessible format when needed.

States should make available additional training on an individualized, as needed basis. The need for such training of an individual who provides personal assistance should be described in and carried out as part of the Individualized Service Plan. Federal legislation should further specify that a PAS user may require that personal assistance providers be trained in the skills required to meet the services called for in the ISP. Moreover, the PAS legislation should require States to review, revise and waive nurse practice act requirements which unnecessarily hinder personal assistants from being trained and/or carrying out their responsibilities.

PAS PROVIDER COMPENSATION AND RELATED ISSUES

In order to assure high quality in services, a federal PAS statute should require that personal assistants are meaningfully compensated for their labors and receive fringe benefits comparable to those available to other para professionals in similar fields.

The compensation of personal assistants should be meaningfully related to such factors as:

- the required skill level of the personal assistant as specified in the person's ISP;
- the education and training required of the personal assistant
- the geographic area and local labor pay rates;
- the duties and skills required by the ISP;
- the length of service/experience of the personal assistant; and,
- night and weekend shift differentials.

Compensation for full-time assistants should include traditional employee benefits, e.g., health insurance; sick and annual leave; FICA; workers' compensation and unemployment insurance. In addition, assistants should have liability insurance coverage. Benefits for part-time workers should be prorated to their hours worked. States should be required to establish mechanisms (e.g., benefits pools) for fringe benefits to assist individual providers and small employers to acquire benefits at a reasonable cost. The legislation should encourage States to provide additional benefits to PAS providers which are available to state employees, including: Retirement; Professional development; Employee credit unions; and, Disability Insurance.

The legislation should also provide incentives to the States to investigate, develop and implement promising and innovative approaches for:

- determining the compensation rate for ISPs requiring different levels of skills, experiences and training;
- encouraging PAS users and their personal assistants to develop and maintain positive, productive and enduring working relationships as a means of preventing abuse and neglect, high turnover rates and burnout;
- enhancing career opportunities for personal assistants in ways which encourage individuals to remain in the PAS field.

For PAS users who rely on management assistance, recruitment, screening, and referral services, there should be up-front criminal background checks and job-interview screening to determine the general qualifications of those seeking personal assistance positions. PAS users should be able to assume that basic quality measures have been met, including that the applicant or service

provider has been screened and that he/she is, in fact, qualified to do the job. Finally, States should establish mechanisms and funding resources to develop and maintain a cadre of trained personal assistants who can provide PAS to users on both an on-going and emergency basis.

QUALITY ASSURANCE

The federal PAS statute should include requirements for States to develop and implement a system of quality assurance to foster quality and excellence in every aspect of the design, delivery and evaluation of user responsive personal assistance services. Such a system of quality assurance should be premised upon the following major assumptions and guiding principles:

1. Quality is defined best in terms of the individual, based on desired life outcomes that the person, their legal representative and/or advocate, recognize as important.
2. These outcomes can include integration into one's community, participation in desired activities, increased mobility, more efficient daily living, enhanced communication, general well-being, self-direction, productivity, employment, or an increase in social skills. (Note: An individual need not demonstrate an ability to achieve a particular life outcome to recognize it as important or to work towards it.)
3. It is impossible to ensure a total absence of abuse. However, abuse, neglect and exploitation of individuals with disabilities can be significantly minimized and prevented by:
 - promoting quality services;
 - fostering maximum self-determination;
 - recognizing the dignity of risk-taking;
 - ensuring that safeguards are in place to identify and respond immediately and effectively to instances of abuse, neglect or exploitation;
 - screening of PAS providers;
 - providing information on abuse, neglect and exploitation as part of the orientation;
 - training PAS providers; and
 - training PAS users as needed.

State PAS Quality Assurance systems should develop and put in place user-friendly policies and practices that:

- affirm that PAS users must drive all aspects of the process;
- ensure that QA is recognized as a prime consideration in every step involving the requesting, offering and providing of PAS;
- affirm that PAS users must be assumed to be able to be independent*, unless demonstrated otherwise
- recognize QA as an on-going individualized and comprehensive assessment of services in relation to the desired outcomes of the PAS user or their legally appointed representative, and/or advocate;
- ensure the person is satisfied with the quality of the service(s) provided;

- take a pro-active approach, anticipate, respond to and solve problems and challenges in a manner that does not go beyond the need of the individual for support;
- provide for a system of "early warning signals" for identifying and remedying current or potential problems (e.g., excessive staff turnover);
- ensure that each individual's ISP has a QA component in it specifying the type/level of QA support and assistance to be in place (e.g., drop-in visits, natural supports and citizen advocacy services);
- ensure that if problems are discovered, it triggers a remedy and, if warranted, a re-examination of the QA component of the individual's ISP;
- provide for background checks and job-interview screens to determine the general qualifications of those seeking personal assistant positions;
- ensure that the service provided meets measurable standards of quality and apply to family and non-family providers of PAS, as appropriate;
- provide incentives for best practices and sanctions for undesirable practice; and,
- provide for enhanced QA support and assistance to people who are at-risk or particularly vulnerable to abuse, neglect or exploitation.

* PLEASE NOTE: This use of this term is consistent with the definition of "independent living" developed by the National Council on Disability as being "control over one's life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities" (National Policy for Persons with Disabilities, 1983). In its 1986 Report, Toward Independence, the NCD further comments that: "Living independently includes managing one's affairs, participating in the day-to-day life of the community in a manner of one's own choosing, fulfilling a range of social roles including productive work, and making decisions that lead to self-determination. Community-based services that promote such independence for Americans with disabilities constitute one of the most promising service delivery strategies for our Nation." p.43.

It is critical that PAS users be given the support they need to gain, maintain and improve competencies and skills required to exert greater control over their own lives. In many instances, this should include providing management training or support to assist a person in having as much effective control over services and personnel as possible. Whenever necessary, assistance should be provided to enable an individual to be more self-directing and/or to assist him/her to maximize his/her interaction with his/her personal assistant. If an user requires or requests an advocate, the primary role of that advocate should be to elicit and advocate for their views, choices and preferences of the individual with a disability.

The State system must have varying levels of quality assurance support because individual abilities and preferences regarding quality will vary. Available support levels should be sensitive and responsive to factors such as the nature/level of one's disability; life experiences; individual needs and preferences; communications

abilities; willingness, interest or capacity in playing a significant role in assessing quality; and those supports necessary to enable a quality assurance role.

Moreover, each State's PAS QA system should provide for independent assessments of quality and consumer satisfaction. PAS users, their families and advocates should be involved in every aspect of designing and carrying out these assessments. Such assessments should be made by persons or organizations independent of the service provider or the state. Each independent assessment should include a review of life outcome measures and the review of quality must be linked to the outcomes. The timing of such assessments may vary based on individual need, but at minimum, must be annual or semi-annual as indicated in the ISP. Assessments also must include solicitation of the consumer's suggestions for improvements. Additionally, in-home assessments of service delivery must focus on the service being delivered.

Finally, in regards to State Planning requirements, each State's plan should clearly describe the ways in which PAS quality assurance program will fit into the overall system while still retaining its independence. The State Plan also should define and describe what role(s) the Protection and Advocacy system, the Independent Living Centers, the Developmental Disabilities Planning Council, Area Agencies on Aging, child protective services and other public/private entities should play in PAS QA efforts. Moreover, States should be required to use feedback from quality assessment and user satisfaction surveys in revising the plan annually. This approach should be flexible enough to encourage best practices to develop.

ASSURING RIGHTS PROTECTION AND DUE PROCESS

The following are the basic rights protection and due process procedures that should be established under a federal PAS statute:

An Established Appeals Process:

The PAS legislation should establish a basic appeals process similar to those in IDEA and the Rehabilitation Act which would be used to resolve any disputes between an individual with a disability and any State entity, program or individual providing personal assistance services to the person. While both IDEA and the Rehab Act include procedural safeguards intended to ensure the impartiality of the hearing process, the actual implementation of these provisions often falls short of the overall intent. Hence, the appeals process adopted for PAS should include the current procedural safeguards found in these two laws and some additional safeguards as well. Specifically, PAS legislation should include the following provisions.

1. **Purpose of the Appeals Process** -- The legislation should clearly state the purpose for establishing the appeals process.

2. **Informing Affected Individuals** -- All persons seeking or receiving services funded under the legislation must be informed of the procedural safeguards available under it. This notice should include the names and addresses of the individuals or agencies with whom appeals may be filed. It also should include the name(s) and address(es) of the Protection and Advocacy System(s) where they may obtain advocacy or legal services and/or assistance. This information must be provided during all PAS orientation, during the development of the ISP and at each ISP review.

3. **Notification of Change in Service Status** individuals receiving services must be given a timely and adequate written notice prior to changing, reducing or terminating services. Such notice must explain the reason for the change and an estimate of the date that the change will occur.

4. **Issues an Applicant or PAS User Can Appeal** -- The legislation should identify the actions, issues, and circumstances which an individual can appeal.

5. **Informal Review** -- It should permit the development of an informal and voluntary administrative review process if it is likely to result in a timely resolution of disagreements in particular instances. However, it should further make clear that this process may not be used as a means to delay a formal hearing unless the parties agree to do so. The choice of whether to use this approach needs to rest with the applicant or PAS user.

6. **Mediation/Negotiation** -- The legislation should encourage but not mandate that an attempt be made to mediate or negotiate a resolution between the individual with a disability and any State entity, program or individual providing personal assistance services to the person. Decisions affecting when and whether to mediate a dispute shall be made solely by the PAS user or other authorized representative.

7. **The Minimum Formal Review Procedures** -- The legislation also should clearly delineate the minimum requirements that must be met by any formal review process that is used to resolve conflicts which arise between individuals with disabilities and the programs that provide them personal assistance services funded under it.

These minimum requirements should:

--mandate the use of impartial hearing officers in any formal review procedures;

-- establish minimum requirements for serving as an impartial hearing officer; and,

-- ensure that a hearing is held to investigate and resolve any conflict involving the requesting, offering and providing of personal assistance services, within 45 days of a request by an applicant or PAS user.

The rights protection and due process section should further direct States to develop and put in place user-friendly policies and practices that:

- specify that an applicant or PAS user or, if appropriate, the individual's parent, guardian, or advocate, must be afforded an opportunity to present evidence, information, and witnesses to the impartial hearing officer;
- assure an applicant or PAS user of their right to be represented by counsel or another advocate, and to examine all witnesses and other relevant sources of information and evidence; and,
- prohibit the introduction of any evidence at the hearing that has not been disclosed to the individual with a disability at least five days before the hearing.

The impartial hearing officer should be required to make a decision based on the provisions of the law, governing regulations, and, if applicable, the State Plan for PAS, and provide the individual with a disability or, if appropriate, the individual's parent, guardian, or other representative, and to the Director of the service providing agency a full written report of the findings and grounds for the decision within 30 days of the completion of the hearing. The individual with a disability must be provided the final decision of the impartial hearing officer in an accessible format. Upon request, the individual must be provided with a record of the hearing in an accessible format.

Similarly, the rights protection and due process section should make clear that any accommodations necessary to ensure the full participation of the individual with a disability or, if appropriate, a parent, guardian, or other representative at any stage of the due process procedures should be provided at public expense. This would include such things as ASL interpreters or interpreters fluent in the primary language of the individual.

In addition, each hearing involving oral arguments must be conducted at a time and place which is reasonably convenient to the parties involved. The impartial hearing procedures should provide for reasonable time extensions for good cause shown at the request of one or both parties.

8. Conditions for Continuing Services Pending an Informal Review or a Formal Hearing. All services called for in a user's ISP shall be provided to the individual throughout the appeals process.

9. Private Right of Action -- Any party aggrieved by the findings and decision made by an impartial hearing officer should have the right to bring a civil action in any state court of competent jurisdiction or in any district court of the United States within four months of the date of the issuance of the hearing officer's written decision.

10. Utilizing An Existing Protection and Advocacy System to Resolve Disputes -- The legislation should also provide incentives to States to develop and implement innovative approaches utilizing existing P&A systems in investigating and resolving disputes involving the requesting, offering or providing of personal assistance services.

DEFINITION OF MENTAL RETARDATION

Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18.

APPLICATION OF THE DEFINITION

The following four assumptions are essential to the application of the definition:

1. Valid assessment considers cultural and linguistic diversity as well as differences in communication and behavioral factors;
2. The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs for supports;
3. Specific adaptive limitations often coexist with strengths in other adaptive skills or other personal capabilities; and
4. With appropriate supports over a sustained period, the life functioning of the person with mental retardation will generally improve.

SOURCE: Mental Retardation: Definition, Classification,
and Systems of Supports

9th Edition
American Association on Mental Retardation

DISABILITY/SENIOR
LONG TERM SERVICES APPROACHCCD
Appendix 3

ELIGIBILITY CRITERIA

1. All persons who are eligible for SSI because of disability will be presumptively eligible for the program. This does not mean that there is a presumptive entitlement to services. Each person will be assessed for their service needs through the regular assessment process.
2. Persons requiring human assistance with 3 or more ADLs.
3. Persons who because of cognitive or other mental impairments
 - (a) require substantial supervision; or
 - (b) require substantial assistance to perform four out of seven IADLs (taking medications, managing money, meal preparation, shopping, light housework, using the telephone or getting around the community); or
 - (c) who have an equivalent level of impairment resulting from a combination of the need for supervision, the need for assistance in performing ADLs and IADLs, and other relevant factors, such as medical or health needs.
4. Children who are unable to function independently, appropriately and (or) effectively in an age appropriate manner (SSI criteria).
5. The Secretary will have the discretion to develop eligibility criteria to accommodate the needs of individuals with extraordinary circumstances, and individuals with a comparable level of impairment resulting from factors such as:
 - a) a combination of the need for assistance in performing ADLs and IADLs, b) a combination of cognitive/mental and physical impairments, and c) and other relevant factors such as unstable medical conditions or sensory disabilities, which are not captured by standard eligibility criteria.

FEATURES OF CONSUMER PARTICIPATION, QUALITY ASSURANCE,
AND STATE SYSTEMS DESIGN

The following features of consumer participation, quality assurance, and state systems design are offered for use with various options for a long term services and supports system. The features may need alteration depending on the context in which the key elements are used. These key features should be considered in the light of previous discussions with the Working Group members regarding basic principles and philosophies for long term services for people with disabilities of all ages (e.g., consumer-focused, consumer-driven, community services, promotion of independence and community integration, etc.)

Systems Planning

1. Each Governor must establish an independent state policy board on LTS which includes a majority of consumers and their representatives and which is representative of the broad disability community (cross-disability representation) including people of all ages. The board should also include representatives of key state agencies, other governmental representatives, providers, and the general public. The board must be independent of other state agencies, with adequate staffing and control of its own budget for carrying out its duties. The disability community must have the right to nominate potential members of the board and the Governor must explain any failure to appoint such nominees as well as find similarly qualified people to serve instead. (See the Rehabilitation Act for a precedent.)
2. Each state should be required to develop a consumer-driven long-range strategic plan on all aspects of the design, delivery, evaluation and future directions of the LTS programs, services and activities in the State. The plan should be a five-year plan and should be updated annually. The plan should cover all LTS programs in the state (including community and institutional services) and indicate how the state will assure that the needs of all the diverse groups of eligible people will be adequately addressed. The plan should be based on the valued outcomes for consumers as defined in the authorizing legislation and describe how the state will increase and/or redirect resources to the community. The plan should further describe the extent and ways in which all long term services and service systems, including existing ones, will seek to promote the policy values of the Americans with Disabilities Act which call for the full integration and inclusion of Americans with disabilities of all ages into every aspect of American community life.
3. A state's long-range strategic plan should be prepared in consultation with the State Policy Board. The plan should be approved by the state, with modifications as necessary and with written explanations of any rejections or changes in the plan. The plan should specify how funds will be spent, and delineate lines of responsibilities regarding all aspects of the design, delivery and evaluation of LTS programs, services and activities. The plan should evaluate and implement strategies to meet the needs of unserved or underserved groups and geographic areas of the state. Feedback from quality assessment and consumer satisfaction assurance activities must be used in preparing and updating the plan annually. If a national long term services and supports program must be phased in, the plan must specify the proposed phase-in of eligibility and priority order, if any, of people to be served.
4. A state's long-range strategic plan should include implementation timelines.
5. The public, particularly LTS users and their families, must be afforded an opportunity to be involved in the development and revision of the plan, through public hearings and other procedures, as well as the monitoring and evaluation of state plan implementation. The plan should be widely disseminated throughout the state in accessible formats so that availability is assured for consumers, families, advocates, and organizations serving people with disabilities. The state shall take into account and respond to significant suggestions from the public.

Systems Administration and Coordination

6. States should be responsible for the administration and coordination of all the long term services programs. The state plan should specify how the programs will be administered and the policies and procedures for assuring coordination of all long-term services and service systems within the state, including existing state/local aging agencies, mental health and mental retardation/developmental disability agencies, children with special health care needs agencies, and any other specialized agencies which provide long-term services as well as coordination with other relevant state agencies on education, health care, and rehabilitation.
7. The delivery of LTS should be built upon the existing state and local LTS infrastructure, with restructuring or adjustments, as necessary, to meet the needs of groups previously unserved or underserved.
8. Federal legislation should define the administrative parameters for the new program.

Services

9. Because there is an enormous variation among the states in the way LTS are organized and delivered, federal legislation must contain clear specifications regarding desired service outcomes, while leaving the states sufficient latitude to determine the most appropriate ways of achieving these outcomes given their own unique situations and service delivery infrastructure.
10. Every eligible person must have an Individual Service Plan (ISP) (for children, a Family Service Plan) which is to be developed jointly by the service manager/coordinator and the recipient of services. The ISP/FSP should begin with the individual's self-assessment of his or her needs (for children, the family's needs) to the maximum extent possible. When appropriate, the individual's representative/guardian should also be involved in the assessment and decision-making process.

Quality Assurance

11. A state's long-range strategic plan should establish and describe a comprehensive quality assurance system that includes the following elements:
 - a. Appropriate quality assurance measures must be implemented statewide and at the local level. Such measures should foster quality and excellence in every aspect of the design, provision, and evaluation of long-term services and supports.
 - b. Consumers and families should have a primary role in defining and assessing quality of services.
 - c. Quality assurance systems should have safeguards in place to identify and respond immediately and effectively to instances of abuse, neglect, and exploitation.
 - d. Individualized quality assurance provisions should be built into each ISP/FSP and be tailored to each person's/family's need and preferences regarding the delivery of LTS. This approach will help to target resources to those who most need substantial quality oversight protection while not imposing extensive protection mechanisms on those consumers who neither need nor want such oversight.
 - e. There must be specific policies and procedures to protect the privacy and confidentiality of program participants.

- f. Independent periodic assessments of quality and consumer satisfaction should be conducted at least annually with appropriate consumer protections for confidentiality. Such assessments should address whether individual's/family's goals in the system are being met as well as whether the state is meeting requirements for quality assurance.
 - g. There should be federal guidelines for the inclusion of timely due process procedures in the state plan.
12. Individual protections should be in place, including grievance procedures to handle complaints or disputes; protection of an individual's current services while complaints are being addressed (see IDEA for precedent); a permissive alternative dispute resolution process; and a private right of action with availability of attorneys fees.
13. There should be a clear federal role for ensuring quality of services with enforcement mechanisms to ensure state and provider compliance.
- a. The federal government should develop minimum requirements for protecting the health and safety of consumers and for preventing abuse or exploitation and should monitor the states' performance in maintaining such standards. Such standards should be developed in a manner to maintain maximum flexibility for serving individual needs and should avoid micro-managing of services; standards would be different for different settings.
 - b. Federal reviews should also address outcome from the perspective of consumers and strive to avoid "paper compliance" results. Such reviews should consider whether individual consumer needs are being met by the system and should address the actual involvement of the consumer in decisions regarding individualized/family services and quality assurance mechanisms.
 - c. Federal review should address the states' compliance with its own quality assurance system and with implementation of its state plan. Federal review should also address the extent of a state's responsiveness to consumer input regarding the system as a whole and the responsiveness of the annual updating of the five-year plan.
 - d. The federal government should have enforcement mechanisms to ensure compliance. Such mechanisms should allow for intermediate sanctions as well as complete "decertification".

Chairman STARK. Mr. McConnell.

STATEMENT OF STEPHEN McCONNELL, CHAIR, LONG-TERM CARE CAMPAIGN, AND SENIOR VICE PRESIDENT FOR PUBLIC POLICY FOR THE ALZHEIMER'S ASSOCIATION

Mr. McCONNELL. Mr. Chairman, and members of the subcommittee, I am here as chairman of the Long-Term Care Campaign and the senior vice president of public policy for the Alzheimer's Association. The long-term care campaign consists of 137 national consumer organizations representing the elderly, persons with disabilities, women, churches, labor, and veterans.

With your permission I would like to submit a complete list of the 137 organization.

Chairman STARK. Without objection.

[The following was subsequently received:]

137 Cooperating Organizations

June 1, 1993

Alzheimer's Association
 Amalgamated Clothing & Textile Workers Union
 American Association for Marriage and Family Therapy
 American Association of Retired Persons
 American Association of University Women
 American Association on Mental Retardation
 American Baptist Churches
 American Cancer Society
 American Counseling Association
 American Diabetes Association
 American Federation of Government Employees
 American Federation of Teachers
 AFL-CIO - American Federation of Labor - Congress of Industrial Organizations
 AFSCME - Amer. Fed. of State, County and Municipal Employees
 American Jewish Congress
 American Nurses Association
 American Health Planning Association
 American Medical Student Association
 American Occupational Therapy Association, Inc.
 American Physical Therapy Association
 American Public Health Association
 American Public Welfare Association
 American Society on Aging
 American Speech-Language-Hearing Association
 Americans for Democratic Action, Inc.
 Americans for Indian Opportunity Association
 Amyotrophic Lateral Sclerosis Association
 ACDRN - Assn. of Community Organizations for Reform Now
 B'nai B'rith Women
 BPW/USA (Nat. Fed. of Business and Prof. Women's Clubs)
 Catholic Charities USA
 Catholic Golden Age
 Center for Community Change
 Center for Law and Social Policy
 Center on Budget and Policy Priorities
 Central Conference of American Rabbis
 Child Welfare League
 Christic Institute
 Church Women United
 Citizen Action
 Coalition of Labor Union Women
 Congress of National Black Churches
 Consumer Federation of America
 Consumers Union
 Council of Jewish Federations
 Displaced Homemakers Network
 Epilepsy Foundation of America
 Family Service America
 Family Survival Project
 Families USA
 Federally Employed Women
 Gray Panthers
 Huntington's Disease Society of America
 International Ladies' Garment Workers' Union
 Joseph P. Kennedy Jr. Foundation
 Lupus Foundation of America, Inc.
 National Alliance for the Mentally Ill
 NAACP (Nat. Assn. for the Advancement of Colored People)
 National Association for the Hispanic Elderly
 National Association for Home Care
 National Association of Area Agencies on Aging
 National Association of Counties
 National Assn. of Developmental Disabilities Council
 National Assn. of Foster Grandparent Program Directors
 National Association of Meal Programs
 National Association of Neighborhoods
 National Assn. of Nutrition and Aging Services Programs
 National Assn. of Private Geriatric Care Managers
 National Assn. of Protection and Advocacy Systems
 National Assn. of Rehab. Prof. in the Private Sector
 National Assn. of Retired Federal Employees
 National Assn. of RSVP Directors
 National Assn. of Senior Companion Program Directors
 National Assn. of Social Workers
 National Assn. of State Units on Aging
 National Caucus and Center on Black Aged, Inc.
 National Center for Policy Alternatives
 National Citizens' Coalition for Nursing Home Reform
 National Community Action Foundation
 National Consumers League
 National Council of Catholic Women
 National Council of Churches
 National Council of Jewish Women
 National Council of Negro Women
 National Council of Senior Citizens
 National Council on Independent Living
 National Council on the Aging
 National Easter Seal Society
 National Education Association
 National Farmers Union
 National Head Injury Foundation
 National Health Council
 National Hispanic Council on Aging
 National Institute for Women of Color
 National Institute on Adult Daycare
 National Institute on Community-Based Long-Term Care
 National League for Nursing
 National Mental Health Association
 National Multiple Sclerosis Society
 National Organization for Women
 National Parkinson Foundation
 National PTA
 National Rehabilitation Association
 National Union of Hospital and Health Care Employees
 National Urban League, Inc.
 National Voluntary Organizations for Independent Living for the Aging
 National Women's Health Network
 National Women's Law Center
 National Women's Political Caucus
 9 to 5 - National Association of Working Women
 NOW Legal Defense and Education Fund
 Older Women's League
 Oley Foundation for Home Parenteral and Enteral Nutrition
 Organization of Chinese Americans, Inc.
 Paralyzed Veterans of America
 Public Employees Department, AFL-CIO
 Retired Officers
 Rural Coalition
 Self Help for Hard of Hearing People, Inc.
 Service Employees International Union
 Sick Kids [Need] Involved People, Inc.
 The Arc
 Tourette Syndrome Association
 Union of American Hebrew Congregations
 United Auto Workers
 United Cerebral Palsy Association
 United Church of Christ
 United Food and Commercial Workers Union
 United Methodist Church Board of Global Ministries, Health & Welfare Ministries Department and Women's Division
 United Seniors Health Cooperative
 United States Conference of Local Health Officers
 United States Conference of Mayors
 United States Student Association
 Visiting Nurse Associations of America
 The Well Spouse Foundation
 Women's League for Conservative Judaism
 World Institute on Disability

Mr. McCONNELL. The campaign was organized in 1987 to change our health care system. A system that discriminates by disease and disability. If you have a heart attack and need surgery or you have cancer and need chemotherapy, the system recognizes your health care needs and insures them. But if your child has cerebral palsy, if you suffer a spinal cord injury or you get Alzheimer's disease, the system ignores you because long-term care doesn't involve doctors or hospitals.

No one understands this better than you, Mr. Chairman. You have insisted that long-term care be a part of this health care reform. I would like to acknowledge Mr. McDermott for his and Mr. Levin, who is the principal sponsor of the family caregiving support effort.

Now President Clinton joins us with a far-reaching proposal for home and community care. None of the other proposals on the table offers families any real hope for long-term care protection. The President's proposal contains a number of features that are absolutely essential to the members of the long-term care campaign. First, it begins in the right place with home and community-based services.

Second, it is a program for persons with disabilities of all ages and income.

Third, it includes specific eligibility language to assure coverage for persons with cognitive and mental impairments as well as physical disabilities.

Fourth, it provides consumer choice of services and providers.

Finally, it is flexible so that services can meet individual needs through personal assistance, day care, respite, home modifications and so forth.

Speaking on behalf of the Alzheimer's Association, we enthusiastically endorse the President's long-term care recommendation. We do understand why you need to understand what a disease like Alzheimer's does to a family. Families exhaust themselves physically, emotionally, and financially to care for the people they love. And they get little help doing it unless they put their loved one in a nursing home, spend all their resources, their retirement savings, even their college tuition to pay for that care.

This system makes no sense. The President would change it. By providing some help through a program like the President is proposing, we make it possible for families to stay together and for families to continue their central role as care givers.

We hear a lot of talk about public-private partnerships. The President is proposing the ultimate partnership, a partnership with families.

All of the organizations in the long-term care campaign and all of the families and 121 chapters that make up the Alzheimer's Association are prepared to work with you to enable families dealing with chronic illnesses and disabilities to get the help they cannot get today.

Mr. Chairman, in closing I would like to point out that while my statement has mostly emphasized the positive things in the President's proposal and we haven't dealt with some of the limitations, I think the biggest limitations we face and the problems we face with long-term care are reflected in this morning's health section

of The Washington Post; 16 pages devoted to health reform. A small section of that devoted to issues of the elderly. Only two paragraphs devoted to long-term care.

Our opinion—leaders and many of your colleagues in Congress don't even understand yet the importance of long-term care to people like Jenifer and the families we are talking about. We could spend all of our time talking about the small things that need to be altered, but if we don't talk about the need for long-term care and get moving toward solving this problem, we are going to short-change our future.

Thank you very much.

Chairman STARK. Thank you very much.

[The prepared statement follows.]



Testimony of

Stephen McConnell, Alzheimer's Association
Representing the Long Term Care Campaign

Before the
U.S. House of Representatives
Committee on Ways and Means Committee, Subcommittee on Health
The Honorable Fortney "Pete" Stark, Chairman

November 2, 1993

Mr. Chairman. I am here today as Chair of the Long Term Care Campaign and as senior vice-president for public policy of the Alzheimer's Association.

The Long Term Care Campaign is a coalition of 137 national consumer organizations organized in 1987 to get long term care into our health care system. The Campaign is made up of organizations representing older Americans, persons with disabilities, women, churches, labor, nurses and veterans. (I would like to submit a list of the member organizations for the hearing record.)

The makeup of the Campaign underscores a central truth about long term care that too frequently gets missed in the discussion. This is not an aging issue. It is a family issue. It affects people of every age. One third of all persons who need long term care are children and younger adults. But regardless of the age of the person with the illness or disability, every person in the family -- parent, spouse, sibling, child, grandchild -- is affected.

We have a health care system now that discriminates by disease and disability. If you have a heart attack and need surgery, or if you have cancer and need chemotherapy the system recognizes your health care needs and insures them. But if your child has cerebral palsy, if you suffer a spinal cord injury, if you get Alzheimer's disease, the system ignores you because the type of health care you need -- long term care -- is not provided in hospitals or doctors' offices.

97% of American families are uninsured against the devastating cost of long term care.

We organized the Long Term Care Campaign to change that system. You have been with us from the start, Mr. Chairman, insisting that long term care be part of health care reform, as has Mr. McDermott and the supporters of his legislation. Now President Clinton joins us with a far-reaching proposal for home and community care. None of the other proposals on the table offers families any real long term care protection.

The President's proposal contains a number of features which the Long Term Care Campaign considers absolutely essential:

- First, it begins in exactly the right place, with home and community care. The President's plan will turn the system upside down. Instead of forcing people into nursing homes -- where no one wants to be -- his plan provides services in settings that are more humane, more appropriate, and for the vast majority of people less expensive.
- Second, it is a program for persons with disabilities of all ages and income, with protections for low-income families and cost-sharing for those who can afford to contribute.
- Third, it includes specific eligibility language to assure coverage for persons with cognitive and mental impairments as well as physical disabilities.
- Fourth, it provides consumer choice of services and providers.
- Fifth, it is flexible, so that services can meet individual needs, through personal assistance, day care, respite, home modifications, habilitation and rehabilitation, and services in community residential settings.

Speaking on behalf of the Alzheimer's Association, we enthusiastically endorse the President's long term care recommendations. To understand why, you need to understand what a disease like Alzheimer's does to a family. Taking care of a person with dementia is an unrelenting, round-the-clock job that involves the most intimate aspects of daily life. Mr. Jones dresses and feeds his wife every day because she has forgotten how. Mrs. Adams bathes and diapers her father after her own children leave for school. Fifteen-year old Sam comes home after school to watch grandpa so that he does not wander away from the house and get lost.

Families exhaust themselves -- physically, emotionally, financially -- to care for the people they love. And they get little help doing it, unless they put their loved one in a nursing home. Even then, help comes only after they have spent everything -- current income, retirement savings, college tuition funds -- to pay for care.

* The system makes no sense. The President would change it.

Of course the Alzheimer's Association is concerned about the cost and quality of care in nursing homes -- at least half of the residents have dementia. But we believe the President is doing exactly the right thing by focusing attention now on home and community care. That is where most people with dementia live. It is where their families want them to be -- in an environment that is as familiar and homelike as possible. By providing some help, through a program like the President is proposing, we make it possible for families to stay together. And we allow families to continue their central role as caregivers, instead of turning everything over to a paid provider.

We do not ignore the central concern Congress must have about cost. The President is proposing significant new expenditures for long term care. But there is mounting evidence that such expenditures will yield important savings, in nursing home costs and in avoidable hospital expenses.

Let me cite just one recent study -- from northern California. Researchers carefully measured the total cost of care for persons with Alzheimer's. One group lived in nursing homes. The other -- with comparable levels of impairment lived at home. When unpaid care is considered, the total cost of care is about the same for persons in both groups -- about \$47,000. But there is a big difference. For those who live at home, three-fourths of the care is provided by family and friends. The total cost of paid care, including medical expenses, is about \$12,500. For those who live in a nursing home, the cost of paid care is three and a half times higher -- \$42,000.

We hear a lot of talk about public-private partnerships. The President is proposing the ultimate partnership -- a partnership with families.

One final comment. However successful we are in helping families at home, there will still be people for whom nursing home care is necessary and appropriate. The President is proposing a change in current law that will make an enormous difference for families who face that decision. He would require that every state establish a medically needy program for nursing home care -- to allow "spend down". This puts an end to the so-called "Medicaid gap" which leaves thousands of families in a dozen states desperate -- with too much monthly income to qualify for Medicaid but not enough to pay the private rate out of their own pockets.

Mr. Chairman, it is easy for families who are dealing with Alzheimer's disease to support wholeheartedly the President's long term care recommendations. If the President's plan is enacted, they -- like hundreds of other families dealing with chronic illnesses and disabilities -- will have help they cannot get today. Finally, they will be part of the system -- and then we can go about perfecting that system.

All of the organizations in the Long Term Care Campaign, and all of the families and 221 Chapters that make up the Alzheimer's Association are prepared to work with you to make that happen.

Chairman STARK. Mr. Richtman.

STATEMENT OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. RICHTMAN. Mr. Chairman, members of the subcommittee, I am pleased to be here today on behalf of the National Committee to Preserve Social Security and Medicare to provide our initial reactions to the administration's long-term care proposal.

Community-based long-term care for the severely disabled of all ages and all incomes constitutes an important step toward full protection against the financial devastation of long-term care. Without long-term care, the National Committee cannot support the health care reform proposal.

All States however, must be required to offer this program and provide improved asset protection for Medicaid nursing home residents.

Today, I want to discuss the uncertainty of the long-term care benefit as well as specific issues related to home and community-based care programs and other long-term care provisions.

The long-term care proposal provides considerable State flexibility, even to the extent that States can choose whether to participate. The enhanced Federal match should be very attractive, but some States may still be concerned about funding the state match. This raises the fear that seniors and the disabled could find themselves in States without this protection.

Congressman McDermott made the point earlier with the previous witness of block grants being cut and that is the same kind of thing we are concerned about with this proposal. We believe a long-term care program should be fully funded and available in all States.

Also, we remain uncomfortable with the conditional connection between the new benefits, long-term care, and savings in Medicare. We hope that Congress is committed to this benefit, even if the full savings do not materialize. Relying on other funding sources for at least some of the costs would be more fair.

While the intent of the legislation is clearly for States to offer a variety of long-term care services, it only mandates personal assistance. Some States may therefore not offer anything else, and thereby limit consumer choice.

The National Committee would like to see other services mandated to assure at least a range of choice.

The proposal also calls for State plans to include quality-of-care provisions, but the proposal doesn't specify what quality standards or guidelines the States must meet.

The Federal Government should set standards to protect consumers against poor quality. The National Committee recommends that the Federal advisory group called for in the legislation follow the Physician Payment Review Commission and the Prospective Payment Review Commission models with a panel of experts and consumers with a staff in an effort to move this country forward on the long-term care front.

This entity should analyze the issues and make recommendations to Congress and the Secretary.

Perhaps an even greater disappointment to us is that the amount of assets that a single Medicaid nursing home resident can keep was not automatically raised from 2,000 to 12,000, but instead was made a State option. Raising the asset protection to 12,000 is considerably less than the 30,000 recommended by the Pepper Commission, and we recommend that at least this 12,000 threshold be made mandatory.

We are very disappointed to see that the nursing home needs allowance will be raised from \$30 to \$70 rather than the \$100 that was in the draft until the final moments the plan was presented to Congress. The needs allowance is all that residents of nursing homes have to spend on personal items.

In conclusion, the National Committee supports the long-term care provision in the Health Security Act, if all States are required to participate in the home community-based program and to raise their Medicaid asset protection for nursing home residents to \$12,000.

In addition, consumers should be offered a variety of services and be assured that certain quality assurance standards are met. The National Committee supports a Federal entity charged with furthering this country's policies on long-term care.

Mr. Chairman, members of the subcommittee, we thank you for the opportunity to testify today and look forward to continuing working with you and your staffs as the health care reform is debated.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF MAX RICHTMAN
EXECUTIVE VICE PRESIDENT
NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE**

Mr. Chairman, members of the Committee, I am Max Richtman, Executive Vice-President of the National Committee to Preserve Social Security and Medicare. I am pleased to be here today to provide our initial reactions to the Administration's long-term care proposal.

Community based long-term care for the severely disabled of all ages and all incomes constitutes an important step towards full protection against the financial devastation of long-term care. Without long-term care, the National Committee cannot support health care reform.

All states, however, must be required to offer this program, and provide improved asset protection for Medicaid nursing home residents. We are also concerned that the long-term care program is not fully implemented until 2003.

Today, I want to address three areas of the Administration's long-term care proposal:

- The uncertainty of the long-term care benefit;
- Specific issues related to the home and community based program; and
- Specific issues related to the other long-term care provisions.

Uncertainty of Benefit

The long-term care proposal provides considerable state flexibility—even to the extent that states can choose whether to participate in the program. The federal match of between 75 and 95 percent should be very attractive, but, undoubtedly, some states will be concerned about funding 5 to 25 percent of the cost. Or they may be concerned about an open-ended obligation to serve the disabled in spite of legislative language to the contrary. This raises the fear that seniors and the disabled could find themselves in states without a long-term care program. Even if a state's plan is approved and it is participating in the program, it is not required to spend up to the maximum allowed for that state. Could a person who has been receiving services all along be cut off from these services at any point? The legislation clearly states that there is no individual entitlement to specific benefits—a provision we are willing to accept—but we will insist that a fully-funded community-based long-term care program be available in all states.

Also, we remain uncomfortable with the conditional connection between the new benefits and savings in Medicare. There is no reason that a benefit for all Americans should be conditional on Medicare savings, some of which will increase out-of-pocket costs to Medicare beneficiaries. Even if it is possible to realize all the proposed savings—and that is a questionable assumption—these savings should have been applied to making Medicare benefits as good as the standard benefit package. We at least hope that Congress is committed to this benefit, even if the full savings do not materialize. Relying on other funding sources for some of the cost would be more fair.

The National Committee is concerned that Medicare savings might be siphoned off for other high priority health care programs, if these programs prove to be more costly than anticipated. We believe a mechanism to earmark Medicare savings to guarantee that they will first be used for the Medicare prescription drug and long-term care benefit. We believe this could be done by making it a part of the budget enforcement provision.

Community-based Long-Term Care—Specific Issues

Consumer empowerment. The National Committee welcomes the strong consumer involvement in the development of the state plans and the emphasis on self-determination in the home and community-based benefit. The plan calls for the disabled to provide, through an advisory council, substantial input into the development of the state plan. It also

intends for states to allow consumers of long-term care benefits considerable flexibility through vouchers or cash payment. Consumers could hire their own attendant or buy their own services. They could even pay a family caregiver to take care of them. A cash payment could provide an important sense of independence rather than the guilt that often comes with being a burden to one's family. States should still assure that caregivers are trained and should periodically have certified care managers assess the care.

Choice of services. The National Committee supports state flexibility. Many states have shown great innovation in setting up long-term care programs and new federal dollars can build on these well-developed programs. But, while the intent of the legislation clearly is for states to offer a variety of long-term care services, it only *mandates* personal assistance. Some states may therefore not offer anything else and thereby eliminate consumer choice. A program rigidly limited to personal assistance cannot serve the different home and community based care needs of all severely disabled individuals. Adult day care, for example, can provide family respite, rehabilitation and socialization. Without transportation, seniors could lose their independence. The National Committee would prefer to see other services mandated as feasible depending on geographic location.

Federal Advisory Group. The National Committee agrees with the proposal to create a federal advisory group. However, we recommend that this entity follow the Physician Payment Review Commission and the Prospective Payment Review Commission models with a staff capable of performing the background work necessary for the advisory group to make decisions and carry out their advisory responsibilities. This panel of experts should begin to work out the myriad of issues related to long-term care. For example, the development of guidelines or standards for care management, adult day care and other services; development of a standardized assessment tool that would mesh with the assessment tool used by most states in nursing homes; development of a sensible payment system for different levels of care or case mix; the analysis of the infrastructure of long-term care and the identification and promulgation of best practice models around the country; best ways to assure quality of care; and the development of standardized data systems for collecting data. In an effort to move the country towards better integration not only of long-term care services, but acute and long-term care services, a central entity is needed at the federal level.

Approval of State Plans. When states decide to participate in the long-term care program, they are required to submit a plan satisfying at least eleven criteria spelled out in the proposed legislation. These criteria are all relevant and are not likely to be perceived as too burdensome to states. The legislation, however, does not spell out what guidelines—preferably standards—will be used at the federal level for approving the plan. When would a criterion be met and not met? A national program—even if state run—should have national standards.

Specific Issues related to the other long-term care provisions

Needs Allowance. In the draft proposal, the Medicaid personal needs allowance for nursing home residents was raised from a meager \$30 to \$100 a month. National Committee is disappointed to see that the nursing home needs allowance in the final plan will only be raised to \$70. The needs allowance is all that the resident has to spend on personal items. In a few places such as Washington, D.C., nursing home residents who already receive a \$70 needs allowance, will not have an increase. There will be additional administrative burdens due to the fact that the federal government will pay the state 100 percent of the difference between what the state currently allows and the \$70 while maintaining the standard Medicaid match for the amount up to \$30.

Asset Protection. Perhaps an even greater disappointment is that the amount of assets that a single Medicaid nursing home resident can keep was not automatically raised from \$2,000 to \$12,000. The National Committee realizes the strain many states are under regarding Medicaid mandates, but we were under the impression that some of that burden would be alleviated under health care reform. In addition, OBRA 93 requires states to implement a program to recover whatever assets a Medicaid nursing home resident may have. The National Committee frankly is disappointed that the President's plan would not do more for nursing home residents. For example, the Pepper Commission recommended that Medicaid residents be able to protect \$30,000 in assets. Raising the asset protection to \$12,000 is small and we recommend that it be made mandatory.

Medically needy. The National Committee is pleased that the medically needy provision will be required in all states. This means that nursing homes would no longer be a closed option for people in some states whose income is above the state requirement for Medicaid eligibility even though they cannot afford the full cost of nursing home care. With this change, as long as the disabled person's assets are no more than the maximum level, he or she can qualify to enter a nursing home. This will be good news for some National Committee members whose incomes are just a few dollars above state limits.

Nursing Home Quality. While the Administration proposal provides small improvements to Medicaid nursing home coverage, it says nothing about the need for increased financing required to improve care in nursing homes. Both licensed nurse and nurse aide staffing is inadequate in nursing homes across the country. The Pepper Commission recognized that "access to quality care would require higher rates than many Medicaid programs now require." In addition, we want to call attention to the fact that current federal regulations do not assure protection of the Nursing Home Reform Act to private pay residents. These protections should be extended to all nursing home residents living in Medicare and Medicaid certified facilities.

Acute and Long-Term Care Demonstration. The National Committee is pleased that the plan gives consideration to recommendations by several groups to integrate acute and long-term care. The plan calls for a maximum of 25 demonstration sites to run for seven years. Presumably, it would even be possible for entire states to become a demonstration site. Unfortunately, \$50 million is all the Administration is requesting for this important demonstration.

Long-Term Care Private Insurance. The National Committee has a long history of advocating for federal standards for private long-term care insurance and is therefore pleased that the Administration plan includes such provisions. The plan establishes an advisory council to develop the standards but requires that certain provisions go into effect six months after the enactment of the law—regardless of whether regulations have been published. We would like the opportunity to respond in greater detail to this section at a later date.

Conclusion. The National Committee supports the long-term care provision in the Health Security Act if all states are required

- 1) to participate in the home and community-based program and
- 2) to raise their Medicaid asset protection for nursing home residents to \$12,000.

In addition, consumers should be offered a variety of services and be assured that certain quality assurance standards are met. The National Committee supports a federal entity charged with furthering this country's policies on long-term care. Mr. Chairman, we thank you for the opportunity to testify and look forward to continuing to work with you and your staff as health care reform is debated.

Chairman STARK. I guess I would address this to you, Max and to Ms. Scarborough. I have some concerns that this Health Security Act tends to promise more than actually will be delivered. And I understand that the polls indicate that support for the plan increase if long-term care services are included. It brings a lot of people to the table.

I wonder if both of you aren't concerned from the standpoint of the AARP and from the National Committee to Preserve Social Security and Medicare, that a large portion of your membership won't receive services under the block grant; are you concerned about that?

Don't you think when your members find out that they may not be entitled to these benefits, for which Medicare funds are being cut—in other words the problem here is that it is being advertised that we are going to cut Medicare and the pharmaceutical benefit is an entitlement or proposed to be an entitlement.

The rest of this—and I am not sure it will do enough for Ms. Simpson's son—is going to go off in some vague State grant, which will not be an entitlement. Now, does that trouble you, Ms. Scarborough, or will it trouble your members?

Ms. SCARBOROUGH. We certainly think things need to be spelled out clearly about what will be covered and who will be covered. So, we will be watching that closely.

Chairman STARK. Max.

Mr. RICHTMAN. Absolutely. I agree. Since the President presented the plan, I participated in a number of forums with Members of Congress. Two days after the plan was presented, I was with Congressman Jim Moran in Falls Church. Two weeks after the plan was presented, I was in Homewood, Illinois with Congressman Mel Reynolds, a member of your committee, and 2 weeks after that in Deerfield Beach in Harry Johnston's district.

Each of these meetings had between 200 and 300 seniors there. I asked, "How many of you watched the President talk about the health care plan on TV?" Every single hand went up. I asked "How many of you understand whether you are going to be better off or worse off if this plan is enacted?" Not a single hand went up.

There is a blank slate out there with seniors and there is a huge responsibility on the part of national organizations and on the Members of Congress to make sure that people understand what is in the plan and what is not in the plan and what is the bottom line value.

Chairman STARK. Let me try a question for each member of the panel. I have heard several of you testify that you feel that long-term care or home health care should be a matter of social insurance. And the Chair feels that way. I would submit that the need for long-term care or home health care assistance as far as we know now is relatively more random and less subject to risk selection than other things in our life, like fire and death.

We can so much more accurately predict the timing. I further feel that if everybody were covered under the same set of restrictions, whether it is number of ADLs or whether it is the need for long-term care, everybody, young children and seniors, that we would then in the second step be able to determine how we could add benefits as we could afford it.

So in a very simplified manner, how would you all feel relative to what the President proposed if we just added funds to either the Medicare and Social Security trust fund, and that obviously would be an increase in the payroll tax. Say we will make available a benefit, as much as we can afford for all Americans for home health care and long-term care, and it will be a trust fund and it will be a similar right as is Social Security for the most part or Medicare. Would that be an acceptable alternative, Ms. Simpson?

Ms. SIMPSON. It sounds good. I am very concerned about the institutional bias that is already in the existing system. Until that is addressed as a reform issue, I don't really know how adding more money really changes things. I want to see systematic change so that I can tap into community-based, consumer-based—

Chairman STARK. But there is not enough for home health assistance or respite care or institutional care. So if we increase it all—

Ms. SIMPSON. I currently pay \$8,000 a year out-of-pocket for personal assistance services for my child. If my child were to be institutionalized, it would cost the taxpayers \$80,000 to \$90,000, depending on what State you lived in. So I think there are some issues there that need to be looked at.

Chairman STARK. Mr. McConnell.

Mr. MCCONNELL. Social insurance for long-term care has been fundamental to the long-term care campaign. That is what we support. I think the question is how much money would be in that system. If it was the same amount of money as currently being proposed by the President, then some decisions would have to be made about who gets services and who doesn't.

Chairman STARK. What if we add Medicaid long-term care and what the President proposed and whatever else we could toss in for good measure? We are not going to have enough and we know that.

Mr. MCCONNELL. That is one of the things that we struggled with the most.

Chairman STARK. The question of the future and how do we raise and who qualifies and how we can control cost in the system.

Mr. MCCONNELL. One of the principles of the long-term care campaign is that it should cover all ages and that it not make distinctions and if you have limited dollars in a social insurance program you are going to have to make decisions about either containing it by age or by level of disability or by type of disability. We are opposed to that.

Chairman STARK. Do you agree that those decisions should be made without regard to income, without regard to age, without regard to residence in what State, and without regard to sex?

Mr. MCCONNELL. Absolutely. You are an enormous supporter of this concept and unfortunately too many of your colleagues are not.

Chairman STARK. They are coming around.

Mr. MCCONNELL. But the question they are raising is how do you contain the costs?

Chairman STARK. Does it make any difference—well, you have to contain the costs either way, whether we do it or the private side does it and we subsidize the private, for profit insurance companies.

Ms. Scarborough.

Ms. SCARBOROUGH. Yes, I agree.

Mr. RICHTMAN. I agree pretty much agree with what has been said by the witnesses. We would like to see some mechanism, I am not exactly sure what it would be, but that would dedicate these revenues for this purpose. As I elaborate in my written statement, it is very easy to picture how some of this money could be siphoned off or maybe we wouldn't see the full Medicare cuts that are being proposed and then you are faced with a much smaller benefit.

Chairman STARK. Thank you.

Mr. McDermott.

Mr. MCDERMOTT. I have a question really for the panel, but I would like to go to you Ms. Simpson.

The question of your son's treatment, does he receive rehabilitation services?

Ms. SIMPSON. No, he is not eligible for vocational rehabilitation—

Mr. MCDERMOTT. Not vocational, but physical.

Ms. SIMPSON. He has been getting physical therapy, occupational and speech therapy in his school-based program under the Individuals with Disabilities Education Act, but he doesn't get those when he is not in school, on vacation, during the summer, or once he graduates school which is age 21. So what happens then is my question?

Mr. MCDERMOTT. What State to you presently live in?

Ms. SIMPSON. I live in the District.

Mr. MCDERMOTT. The District of Columbia?

So when he gets out of school, he will no longer have access to any program to pay for rehabilitation services?

Ms. SIMPSON. That is not my understanding. I think he will be eligible for SSI and Medicaid. So what is in Medicaid, I would want preserved for him.

Chris do you have a comment?

Ms. METZLER. Joshua lives in the District of Columbia and when he reaches age 18 is eligible for SSI, and thus he would be eligible for Medicaid. Under Medicaid at the present time, some of the rehabilitation therapies are covered by the States on an ongoing basis for people who need them over the long term. In addition, some of the States use the home and community-based waiver option under Medicaid to fund ongoing services, such as the kind Joshua would need.

It would depend on what State he was living in whether or not he would get services. These services currently funded under Medicaid provide a great deal of support to many people with disabilities and we would be very concerned about any change to that. We are concerned about earlier drafts of the President's proposal which lumped the money for those services too soon into a program that we weren't sure would be able to meet the kinds of needs for therapies and other support services that people like Joshua have.

Mr. MCDERMOTT. It is my understanding that the President's plan does not anticipate providing rehabilitation services for people with birth defects, whereas they are anticipating rehabilitation services for people who require rehabilitation as a result of an illness or an injury. Is that your understanding?

Ms. METZLER. Our understanding is that on the acute side of the proposal there is that limitation. On the long-term side, rehabilitation and habilitation therapies are among the services that States can choose as an option in their long-term services program.

As Ms. Simpson testified, CCD believes that all of those services are critical to people, particularly for those with severe disabilities, and they need to be provided to those who need them.

The broad benefit package at the beginning is necessary to ensure that people get the services that they need, that they don't lose functioning, and they are able to live independent lives.

Mr. MCDERMOTT. Can any of you on the panel, including you, Ms. Metzler, think of a policy reason why that distinction was made?

Ms. METZLER. Our understanding was that there was a thought that personal assistance services encompassed the basics that anybody might need. That might be true for many of the people that may be eligible. The administration rightly wants to provide flexibility for the individual to choose the services that have the most importance to them and for the State to develop an array and system of services that meet people's needs.

There are a variety of specialized systems out there, both through State governments and local governments as was pointed out by one of the other witnesses. They wanted to provide this flexibility so that the systems could be best designed to meet individual needs and take best advantage of those resources.

Mr. MCDERMOTT. But in effect they leave people with no certainty about what is going to be available?

Ms. METZLER. That is correct.

Mr. MCDERMOTT. And Medicaid, under the President's plan, will disappear; correct?

Ms. METZLER. At the moment we understand that it is on hold for a while to examine the use of Medicaid for long-term services. We would be watchful of this process, in particular long-term services. If Medicaid were to be eliminated, there would be many vulnerable people exposed to the loss of critical services. It is clear that people need assistance because of their disability and by virtue of their low income.

Mr. MCDERMOTT. My understanding is that—as the President's plan envisions—as States begin to come up with their program, they will roll the Medicaid population into the basic program and, therefore, the benefit package which you are suggesting is presently there would no longer be there.

Ms. METZLER. We are concerned about that, but on the other hand, if the program is provided with sufficient resources and sufficient flexibility, there may be an ability for States to use their funds more wisely. In the disability field, we have felt for a long time that in many States there is far too much money spent in institutional services that doesn't benefit enough people as opposed to the lesser amount available in home and community services, which the President's proposal rightly emphasizes.

In your State, I know that the State legislature has been examining that problem of use of institutions over the past year. It is a difficult problem, and we want to see that reversed.

Mr. McDERMOTT. I guess my comment on all of this is that it is pretty hard for me to believe that following the old adage that a bird in the hand is worth two in the bush, that you would be very comfortable with idea of the possibility that there might be things—you are willing to give up Medicaid, which you have, in exchange for something that you might have in the new program if the States decide it is a good idea. That seems like a slender reed to grab ahold of.

Given the history of getting services for people with disabilities in this country, it seems that the potential for sliding back is awfully great. I would be concerned if I were you.

Ms. METZLER. We are concerned and we know that there are people even with our present system who wait for services. The infusion of new resources is very critical as is better use of existing resources.

Mr. McDERMOTT. Thank you very much, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you.

I would like to pick up that thread of discussion. Before I do that, Ms. Simpson, I would like to ask you a few questions because I really think it does help all of us to try to step in the shoes of others, at least for a few minutes, to the extent we possibly can.

What kind of private insurance do you have?

Ms. SIMPSON. Just a regular major med 80/20 copay plan. It fortunately covers dental. This was a new benefit that they got for us. That is something very valuable I think.

Mr. LEVIN. And so are you in rather regular discussions with the carrier about what is covered—what benefits are available for Josh and what aren't? I mean, just describe—

Ms. SIMPSON. I wanted to mention, this is the eighth insurance company that I have dealt with in Joshua's lifetime, and he is only 8-years-old. When you get a new job or your company buys a new plan, you have to deal with all sorts of bureaucrats and paperwork and dealing with claims adjusters can be a nightmare. The one I am dealing with now is over the augmentative communication device.

Thirty to fifty percent of people with cerebral palsy can't talk. A communication/device is something needed to fully function. The item he now has cost \$2,400, not counting evaluation and maintenance. When I called them last year they said, "Yes, we will pay for it."

But, I forgot to get that in writing, because when I submitted the bill a month ago, they said, "We do not cover this." I said "Why not?" They said, "It is not on the list." And I said, "What list? I can't find any list in the plan."

They sent me a list. It listed eyes, limbs, and rental of a wheelchair. I said "This is a functional requirement that I am asking you to pay for. It allows him to communicate. It is not a cosmetic thing. Please pay for it," and I am still waiting. I am still out-of-pocket the \$2,400 which I borrowed from friends.

Mr. LEVIN. The number of policies or carriers you have dealt with has resulted from changes in employment?

Ms. SIMPSON. Two moves. I originally lived in Massachusetts and I moved to Virginia and then I moved into D.C. Two different em-

ployers have bought or rolled into new plans very often. The current employer went for a better deal.

These are the kinds of things that happen. I think they are quite typical of the families that I talk to at the National United Cerebral Palsy Association office. I hear this complaint a lot. Somebody loses a job and they have to switch to mom's plan or a different plan. And of course, when I became divorced, it is just now relying on my plan because my ex-spouse does not have health coverage. He is self-employed and has no plan, so it rests on me to pay the premium and make sure Joshua gets what he needs.

Mr. LEVIN. Has there been any instance when the carriers change when there has been a question of the breadth of coverage for the two of you?

Ms. SIMPSON. Yes. There was one insurer who said "We can't pay for that"—and I think it was physical therapy when he was about 2- or 3-years-old—"because you just changed jobs." This is when my ex-spouse got a job. "We can't cover that because it is a preexisting condition. We won't cover that. Why don't you go to the Elks? Why don't you go to the Knights of Columbus?" So basically they told me to go beg to pay for that.

I bitterly resented that and I still sometimes have to be in a position to have to scrounge around raising funds for the things that he needs.

Mr. LEVIN. Let me ask you a much more general question. In the testimony we heard earlier from Josh Wiener there was this reference, perhaps it was discussed before I arrived, the long-term care systems in Europe are striking for the radical decentralization down to the local level, far below anything being contemplated in the United States. The lessons from other countries as well as the United States strongly point in the direct of local control.

This really picks up Mr. McDermott's question. The suggestion here is that this kind of diversity and State responsibility in long-term care is really something that is necessary.

Any quick reactions to that?

Mr. MCCONNELL. Just a quick comment. I think that because we don't now have the full infrastructure for long-term care, the innovation in long-term care has been taking place at the State level. It varies because many States have been operating under waivers and so forth.

I think the nature of the services and what you have been hearing from people on this panel are so varied, that we need to make sure that those services are tailored to people's needs and not just meeting a national standard.

So in general we are supportive of that kind of flexibility. I think the real question and concern that everyone shares is what are people entitled to? But the actual delivery of and organization of the services we would say is best handled at the local level.

Mr. RICHTMAN. Congressman, we also agree that there is no entitlement that is specific to individual benefits in the proposal and we accept that. But we are concerned that there may not be the variety of services that are needed. While States do need some flexibility, for example in a very rural State it might be a problem to have day care centers in certain parts of that State.

We would like to see something more specific in the plan that would have some Federal requirements on a wider variety of services.

Ms. SCARBOROUGH. I think we agree that the States do need some flexibility in how they implement and carry out these things, but we need standards to make sure that there is quality assurance, mandatory coverage of certain services and that provider reimbursement is more standardized. Those types of concerns will be there for us. We want to watch these.

Ms. METZLER. The Consortium for Citizens with Disabilities submitted some recommendations that we submitted also to the President on system design and consumer participation. I think we would agree that local design—to take advantage of the variety of resources available—is important, as is consumer decisionmaking at the individual level. But what is even more important is to make sure that the people with disabilities who need long-term services are involved in the policy development. The reassurances must be that the programs adhere to certain principles and these need to be clearly articulated at the Federal level.

So we need consumer involvement at the Federal, State and local level in designing and implementing services. That is your best safeguard to assure that the services really meet the needs of people.

Mr. LEVIN. Thank you for the indulgence of my colleagues.

Thank you, Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Thank you. I would like to ask one question of Ms. Scarborough and Mr. McConnell and Mr. Richtman. Medicare is an entitlement and I think there is some confusion in the President's plan over whether or not the long-term care benefit in the community is a Medicare benefit, therefore, an entitlement.

Do you think the membership, your organizations, understand that distinction? And if not, do you have some plan in your organization to educate them about the fact that this is not a Medicare benefit, therefore, that it is not an entitlement?

Ms. SCARBOROUGH. We are working really hard on our educational and communication efforts with our members. Definitely. They probably do not understand that at this point. And we certainly want to make every effort to get that word to them.

Mr. McDERMOTT. Are you using your newsletter or what kind of—

Ms. SCARBOROUGH. Every possible media. Right now we are having field hearings, we are having focus groups. We are using our Modern Maturity magazine, the AARP bulletin, our Highlights publication, every possible way we can.

Mr. McCONNELL. Well, in the case of the Alzheimer's families, they are getting so little help now that the issue of entitlement-nonentitlement is not yet a major consideration. They hear they are going to get something that is an improvement over what they are getting now and they are delighted.

I think politically, it is an issue of how we communicate to people what it is they are going to get and what they won't get. We are doing that through local forums and through our chapters to try to help people understand it, but it is difficult because so much is left

to State option. But again the enthusiasm that I tried to express in my testimony is the enthusiasm of people who are seeing some glimmer of hope, of improvement, no matter how small, and that is significant.

Mr. RICHTMAN. Congressman, we are trying to explain that distinction in our magazine and in forums that we are conducting around the country with our members. We get in our office between 25,000 and 30,000 letters a month on a variety of issues. Lately they have been almost all on health care. So we are responding directly to our members and the inquiries they make in the mail.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

I want to thank the panel very much for their consideration this morning.

We will now hear from Mr. Richard W. Garner, the group vice president and actuary of the CNA Insurance Cos. of Chicago. He is representing the Health Insurance Association of America and he at here is the request of Hillary Rodham Clinton.

Welcome to the committee. Proceed in any manner you are comfortable.

STATEMENT OF RICHARD W. GARNER, GROUP VICE PRESIDENT AND ACTUARY, CNA INSURANCE COMPANY, CHICAGO, ILL., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. GARNER. Thank you. Good morning Mr. Chairman and members of the subcommittee. My name is Richard Garner and I am group vice president and actuary for the CNA Insurance Cos. I am here today on behalf of the Health Insurance Association of America, HIAA, which represents approximately 270 private insurance companies providing health insurance for 65 million Americans.

In addition, HIAA member companies account for almost two-thirds of the 3 million private long-term care insurance policies sold to date.

HIAA welcomes the opportunity to testify today on the issue of long-term care in the context of the Health Security Act. We are encouraged that this legislation addresses our Nation's long-term care needs by promoting a strong public private partnership in long-term care financing.

Our testimony is based on our preliminary review of the administration's plan. HIAA staff is conducting our in-depth analysis of the act. We look forward to the opportunity to discuss our views further with you when our analysis is completed.

Mr. Chairman, the private insurance industry has worked very hard to make a wide variety of product options available to consumers. Currently there are 135 companies who sponsor private long-term care insurance plans. The products have evolved dramatically since first introduced. Most products now sold offer benefits such as inflation protection, nonforfeiture coverage, residential care benefits and alternate care services as standard benefits. Clearly there is now a vast array of reasonably priced product options from which consumers can choose. HIAA believes that a strong public private partnership can best be implemented through three strategies.

First, individual responsibility in planning for exposure to long-term care risks must be encouraged through consumer education.

Consumers must be made aware of the risk of incurring catastrophic expenses, of the wide array of long-term care services and settings offered and of the numerous types of private insurance products available to finance these services.

The second strategy rests on the provision of tax incentives to encourage the purchase of private coverage. Tax clarification will increase the affordability of these products and foster a strong and viable long-term care market. In turn, private insurance will help millions of Americans protect themselves while reducing the drain on Medicaid and other Federal and State programs.

In conjunction with tax clarification, we would support the establishment of Federal standards for long-term care insurance. A Federal seal of approval in the form of standards could build consumer confidence in this market and further expand private coverage.

I must stress, however, that such standards must not be so onerous as to prohibit all but "Cadillac" policies from being sold.

The third strategy focuses scarce public resources on those that cannot afford to finance their own long-term care needs.

Our first major concern relates to the minimum standards themselves.

HIAA and its members share the objectives of policymakers and consumers for strong consumer protection laws. It is not clear, however, that each of the elements in the President's Federal standards proposal meets these criteria.

In particular, HIAA strongly opposes mandated nonforfeiture benefits. These benefits substantially increase the cost of insurance policies and provide uncertain value to consumers. Research conducted on behalf of the NAIC indicated that only 30 percent of those who purchase nonforfeiture benefits will ever use them. Yet all consumers forced to purchase this coverage would pay 30 to 40 percent more for a benefit they would never use.

We would oppose the imposition of Federal or State elements on the amount by which insurance premiums would increase as claims experience unfolds. We believe that policies meeting Federal standards should be allowed for sale in all States. These policies should be approved only in an insurer's State of domicile. This would simplify filing procedures and increase competition.

States should be allowed to develop standards which exceed the Federal standards under State product options as long as consumers also have the option of buying policies that meet Federal standards.

Our second major concern relates to the new national home care program. First we believe a far better use of limited tax dollars would be to target care to the needy.

Second, we are concerned that the public will interpret this new program as a down payment toward a national solution to long-term care and overestimate the level of public insurance available.

Third, the design of the program would make it difficult, if not impossible, for private insurers to provide supplemental home care insurance products.

We applaud the President for including long-term care as part of a comprehensive solution to health care reform. The Health Insurance Association would like to serve as a resource to the administration and Members of Congress in refining proposals to build a strong public private partnership for financing long-term care services.

[The prepared statement follows:]

TESTIMONY OF RICHARD W. GARNER
GROUP VICE PRESIDENT AND ACTUARY
CNA INSURANCE COMPANIES
ON BEHALF OF
HEALTH INSURANCE ASSOCIATION OF AMERICA

Good morning Mr. Chairman and Members of the Subcommittee. My name is Richard W. Garner and I am a Group Vice President and Actuary for the CNA Insurance Companies. I am here today on behalf of the Health Insurance Association of America (HIAA) which represents approximately 270 private insurance companies providing health insurance for 65 million Americans. About 62 percent of the long-term care insurance policies sold have been issued by member companies.

HIAA welcomes the opportunity to testify today on the issue of long-term care in the context of the Administration's health care reform proposal, The Health Security Act. Mr. Chairman, we commend the President for coming forward with an ambitious blueprint for reform of the nation's health care delivery and financing system. With approximately 37 million Americans currently without health insurance coverage, and health care costs consuming an ever greater share of the Gross Domestic Product, there can be no question regarding the imperative for comprehensive reform of our current system. Furthermore, we believe that comprehensive reform of our nation's health care system must include measures which promote a strong public-private partnership in the financing and delivery of long-term care services.

Uninsured people under the age of 65 represent only half the problem of inadequate health insurance protection. Almost 32 million Americans over the age of 65 also face the potentially devastating financial exposure to catastrophic expenditures for long-term care services. If our nation is serious about comprehensive health care reform, we must not abandon our nation's older and disabled Americans.

HIAA believes that the current health care reform debate provides an important opportunity to improve our country's long-term care financing system. We believe that this system best can be improved through three strategies. First, individual responsibility in planning for exposure to long-term care risk must be promoted through consumer education. Consumers must be made aware of the risk of incurring catastrophic expenses, the wide array of long-term care services and settings offered, and the numerous types of private insurance products available to finance these services.

Second, the growth of the private long-term care insurance market must be fostered by educating consumers about long-term care risk and product options and providing tax incentives for purchasing coverage. Tax clarification would increase the affordability of these products, lend additional legitimacy to this coverage and help millions of Americans protect themselves against catastrophic long-term care expenses.

In conjunction with tax clarification, we would support establishing minimum Federal standards for long-term care insurance products that would serve as a "seal of approval," thereby building consumer confidence in private long-term care products. However, such standards must not be so onerous that they prohibit all but "cadillac" policies from being sold. Equally important, consumers should be allowed to purchase federally-approved policies in all states. Separate state approval should not be necessary. In fact, HIAA believes that a requirement for separate state approval would limit consumers' access to a wide range of high quality products by stifling competition in the long-term care market.

Third, HIAA believes that public assistance must be provided for those who are unable to finance their own long-term care expenses. Such assistance could take the form of enhancements to the Medicaid program.

We are pleased to see that the Administration has included several provisions in the Health Security Act which are consistent with both HIAA's goals for strengthening financial

protection for long-term care services and our strategies for achieving these goals. Such provisions include clarifying the tax status of long-term care insurance products; implementing minimum federal standards; authorizing consumer education grants for the development of long-term care information and counseling programs; increasing the Medicaid asset threshold for single individuals from \$2,000 to \$12,000; and raising the personal needs allowance for Medicaid recipients of institutional care.

We have two concerns with the newly proposed national home care program. First, HIAA believes that a far better use of limited tax dollars would be to target care to those unable to protect themselves, and encourage those who can afford to do so, to purchase private protection. Second, we are concerned that the Administration will "sell" the public on this program as a down-payment toward a national solution to long-term care when even this modest home care benefit is estimated to cost \$65 billion over five years. Costs alone dictate that the ultimate solution must be a public-private partnership. It is critical that the Administration clarify to the public that this program is not an entitlement program and that individuals will continue to bear significant responsibilities in financing community-based services.

Mr. Chairman, the testimony below will focus on HIAA's views on the importance of addressing long-term care financing issues as part of health reform and our recommendations on how long-term care financing improvements can best be accomplished. Because the legislative language of the President's proposal has been available for only a few days, however, we hope the Committee would be receptive to more detailed comments after HIAA and its members have been able to do a more thorough review.

I. LONG-TERM CARE IN THE CONTEXT OF HEALTH CARE REFORM

In his speech before Members of Congress on October 27, President Clinton reiterated the six fundamental principles on which his reform plan is based. At least four of these principles are relevant to long-term care reform: security, quality, choice and responsibility. These principles are among those included in HIAA's own Vision for Reform which we constructed last year. I'd like to elaborate on these principles briefly as they pertain to long-term care.

Security

The risk associated with older Americans incurring catastrophic long-term care expenses is equal to the risk to younger Americans of incurring costly primary and acute care expenses. The majority of those requiring such services are 65 or older. Approximately 7.1 million of the 32 million people age 65 and older need long-term care assistance. Seventy-nine percent of this group lives in the community with assistance and 21 percent live in nursing homes.

It is estimated that people age 65 face a 43 percent chance of entering a nursing home sometime during their lives. Of those who do enter nursing homes, 27 percent will stay for a year or more; 21 percent will experience lifetime stays of five years or more and incur enormous expenses to cover their care. Fully half of the age 85 plus population today needs some assistance with activities of daily living due to chronic illness or disability. Others need assistance with activities such as shopping, housekeeping and managing medication and finances. Since the over 85 age group is the fastest growing segment of our population, the needs of our nation's oldest citizens can only continue to grow.

The cost of long-term care services can be financially devastating. The average annual cost of nursing home care nationally is about \$36,000 and can be over twice this amount in certain areas of the country. Community-based services such as home health care also can impose significant financial burdens on the disabled, averaging \$10,000 to \$15,000 annually for someone who needs assistance several times a week.

Clearly, demographic and fiscal trends suggest the need for immediate action to address the long-term care financing needs of our nation's elderly. Despite heightened media attention in recent years to the long-term care needs of older Americans and their families, increased awareness has not resulted in a coordinated approach to our long-term care system. Delivery of these services remains fragmented and financing can be extremely complex. Furthermore, access to appropriate long-term care services often is blocked by inadequate financial protection.

As you know, Mr. Chairman, the Medicare program was never intended to fund long-term episodes of illness for the chronically impaired. Furthermore, individuals must impoverish themselves to become eligible for Medicaid. Access to community-based support under Medicaid is limited and varies tremendously from state to state.

Public benefits for long-term care provide older Americans very little security. A survey published this year by the Employee Benefits Research Institute (EBRI) suggests that the American public is more confused than ever about what the Federal government does and does not pay for long-term care expenses. In fact, an even greater percentage of 1993 EBRI survey respondents indicated that they believed Medicare would pay for their long-term care expenses than those responding to the 1990 survey. These findings underscore the need for the federal and state governments to clarify their roles in financing long-term care and educating the public about how public and private sector responsibilities should be shared in funding this care. Only through such clarification and education will older Americans and their families find true security relative to their long-term care needs.

Individual Responsibility

In outlining the major principles underlying the Administration's plan for health care reform, President Clinton consistently has stressed the importance of individual responsibility by stating that "every American must assume responsibility to bring an out-of-control system under control and put funding on a fair and responsible basis." HIAA believes this principle also must be applied to the long-term care side of the health care equation, and that the public and private sectors must share responsibility for financing long-term care services. Clearly, given the magnitude of long-term care expenses, the government, private industry, and individuals all must share the costs of this burden. Both the federal and state governments are staggering under the pressure of increasing budget constraints. The cost of financing long-term care services, particularly in institutional settings, accounts for a large part of these constraints.

In recent years, the private insurance industry has spearheaded efforts to enhance financial protection for long-term care services. Currently 135 companies offer long-term care insurance coverage. Since 1987, the number of individual policies sold has almost quadrupled, from 815,000 policies sold in December of 1987, to 2.9 million at the end of 1992. Of the policies sold in 1992, 32 percent were employer-sponsored policies. Moreover, the products themselves have changed light years since first introduced to the market.

HIAA analyzed policies of the top fifteen long-term care writers, representing 80 percent of the market of all individual and group association policies sold in 1991. All products analyzed offered coverage for skilled, intermediate and custodial nursing home care as well as home health care services. Thirteen of fifteen companies offered adult day care, 60 percent covered alternate care and 40 percent offered coverage of respite care benefits. All companies offered inflation protection, two-thirds offered nonforfeiture benefits and many companies introduced new benefits. (See Figure 1 for prototype coverage offered in 1991).

It is important to note that consumers themselves are beginning to recognize the need to share responsibility for long-term care risk. A 1990 EBRI study indicated that 43 percent of the respondents felt that the Federal government should accept primary responsibility for financing long-term care costs; only 6 percent felt that individuals should play the primary role. By 1993, only 29 percent of the respondents to EBRI's long-term care survey felt the Federal government should have primary responsibility for this burden. About 17 percent felt that individuals should play the primary role and another 13 percent felt that this should be a family responsibility.

Public opinion regarding willingness to pay for private long-term care insurance further supports the notion of individual and family responsibility for financing long-term care costs. About 65 percent of respondents indicated that they would purchase a policy from a carrier or employer. Almost 60 percent said they would purchase a policy for a family member, such as a spouse, parent, grandparent or child. In addition, respondents to the 1993 survey indicated a willingness to pay significantly more for private coverage than respondents to the 1990 survey. On average, 1993 respondents indicated they would be willing to pay \$927 annually for long-term care insurance. Respondents to the 1991 survey said they would pay, on average, \$488 annually.

Choice

A fourth principle underlying the Health Security Act is choice. HIAA believes that one of the most valuable benefits accruing to those who purchase private long-term care insurance is choice -- the ability to exercise control over which of the many community-based, residential and institutional services available they wish to use -- and the ability to select which providers will deliver the services they choose.

While asset protection is an important reason for purchasing long-term care coverage, it is not the most important reason cited by those who buy policies. In a survey of 14,000 policies purchased in 1990, over half the respondents cited the most important reasons were preserving their independence (30 percent) and being able to afford needed care (20 percent). Protecting assets was cited by only 14 percent as the most important reason for obtaining coverage.

Clearly, individuals who are dependent on public assistance have few choices. The options they do have are conditioned to a large degree upon their state of residence and the state's economic status since federal Medicaid matching funds are determined by the amount states are able to contribute. The development of innovative long-term care insurance plans, and access to this coverage, clearly expands the range of choices consumers have in meeting their long-term care needs.

Private long-term care insurance helps consumers preserve this choice. The continuous expansion of product benefit features has enabled consumers to select among a vast array of options relative to health care services and settings. For example, the HIAA survey revealed that 60 percent of the top fifteen sellers

offer some type of alternate care benefit enabling consumers to receive nontraditional benefits such as special medical care (e.g., services provided by special care units for Alzheimer's Disease); home modifications that enable consumers to remain at home instead of entering an institutional setting (e.g., modifications to bathrooms and kitchens, installation of wheelchair ramps); and care in adult foster homes and assisted living settings. Care management and caregiver training benefits also are being offered as a free-standing benefit by some insurance companies to help older people negotiate the complex web of long-term care services and settings and to train their caregivers to provide services enabling them to remain at home longer.

Quality

A principal goal of the Health Security Act is to improve the quality of care delivered to the American public. HIAA believes that access to private long-term care insurance coverage enhances consumers' access to high quality care in at least two ways. First, private markets create greater incentives for providers to deliver high quality care in order to compete for clients. Second, by expanding the number of individuals paying privately for nursing home and community-based care, it will increase the amount of resources available to long-term care providers and assist them in maintaining high standards of care.

The expansion of private financing for long-term care services also reduces the drain on federal and state Medicaid budgets, a factor that has the potential to improve the adequacy of public reimbursement rates. Since Medicaid nursing home rates on average compensate providers for only about 70 percent of the actual costs of care, enhanced public reimbursement will help guarantee quality care.

II. CONSUMER PROTECTION STANDARDS

A. HIAA Consumer Protection Standards

HIAA and its members share the objectives of policy makers and consumers - strong consumer protection laws and their full enforcement are needed for long-term care insurance. The market will not survive without them. To emphasize the need for unique consumer protection standards in the area of long-term care, in 1991, HIAA adopted a Proposal for Long-term Care Consumer Protection which states the Goals of Long-Term Care Insurance Consumer Protection Regulations and proposes a Consumer "Bill of Rights". It identifies fundamental consumer rights for the purchasers of long-term care insurance. To back up the Bill of Rights, the proposal recommends a series of specific provisions in the areas of company, agent, and consumer education; disclosure; marketing practices; and policy benefit provisions. (See Attachment A).

HIAA believes that the cumulative effect of government regulation should be to create an environment where the benefits of regulation outweigh their costs for consumers, the private sector and government. There are multiple provisions in the current NAIC Model Act and Regulation which HIAA firmly supports as appropriate consumer protection. These include:

- * Requirement that individual policies be guaranteed renewable.
- * Required offer of inflation protection.
- * Prohibition against post-claims underwriting.

- * Requirement that insurers establish auditable marketing standards, for fair and accurate comparisons of policies, notification of limitations of coverage, and notification of availability of senior counseling programs if one exists in the state.
- * Prohibition against prior-hospitalization requirements.
- * Required 30 day free look period with full refund of paid premiums upon return of policy within this period.
- * Penalties on agents and insurers equal to three times the commission rate, or \$10,000, whichever is greater.
- * Required delivery of detailed outline of coverage.
- * Required coverage of Alzheimer's Disease.
- * Prohibition of preexisting condition exclusion period of longer than six months.
- * Minimum standards for home care, including prohibitions against tying benefits for home care to the need for skilled nursing care, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers.
- * Prohibition against conditioning eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.
- * Requirement that group policies provide for continuation and conversion.
- * Loss ratio requirements at least equal to 60 percent for individual policies.
- * Prohibition against twisting, high pressure sales tactics and cold lead advertising.
- * Requirement that agent determine appropriateness of a recommended purchase prior to sale.
- * Required delivery of buyers' guide prior to sale.

In addition, there are several provisions in the HIAA Consumer Protection Framework which go beyond the current NAIC Long-Term Care Model Act and Regulation. They include:

- * Require insurers to establish and implement long-term care education and training programs and materials for their marketing representatives and appropriate home office staff.
- * Require insurers to establish procedures for monitoring the sales practices of their agents. Measures of agent conduct include lapse rates, replacement rates, rescission rates, and application denial rates. Such agent specific data shall not be required until it reaches a credible level.
- * If states have continuing education requirements, require agents licensed as accident and health agents to earn long-term care insurance credits.
- * Require policies to waive premiums while the insured is receiving nursing home benefits.

- * Require insurers to establish and maintain a meaningful update protection program offering policyholders new policy forms, improvements and coverages currently marketed by the insurer.
- * Require insurers to base benefit eligibility criteria upon clinically-based empirical research in the area of disability and long-term care which accounts for the inability of the insured to perform an appropriate number of activities of daily living; or a similar level of disability as can be measured in terms of medical necessity; or a similar level of disability due to cognitive impairment.
- * Require insurers to provide a clear and thorough written definition of the benefit eligibility criteria at the point of sale.
- * Require insurers to inform an applicant about coverage decisions within 60 days after receiving a completed application and all necessary supporting documentation requested by the insurer.
- * Require insurers to establish a thorough claims process which will be explained clearly in written form at the time a claim is filed.
- * Require insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves. In addition, the NAIC should, working with insurers, develop criteria for evaluating insurer reporting data.
- * Require states to report the finally adjudicated violations of a state's long-term care insurance laws or regulations.

B. Provisions in Health Security Act of Concern to HIAA

HIAA supports the President's intent to provide consumers high quality long-term care insurance products that assure consumers good value and adequate protection. We believe that the standards outlined above provide consumers with such assurances. We are concerned, however, that some of the standards contained in The Health Security Act are overly prescriptive and could act as a disservice to consumers. The concerns regarding specific provisions outlined below are based on a preliminary reading of the Act. Our comments are listed in order of their appearance in the legislation and are not ranked according to HIAA's priorities. (The page numbers after each section pertain to the Health Security Act). HIAA would appreciate the opportunity to provide the Committee with additional comments after we have analyzed this new legislation more extensively.

1. Section 2303 - Relation to State Law (p. 430)

This section would allow states to apply standards that exceed minimum federal standards.

HIAA believes that separate state requirements would limit consumers' access to a wide range of long-term care insurance products by stifling competition in the market. Many long-term care insurance sellers have dropped out of the market due to the administrative burden and expense of filing different policies in fifty separate states. The increase in administrative costs resulting from multiple filings and approvals of the same product increase premium costs needlessly.

HIAA recommends requiring insurance companies to file and receive approval for products only in their state of domicile and

establishing a system for reciprocity in other states. Findings of compliance with minimum federal standards in the domiciled state would result in reciprocal approval by all other states. Such a policy would benefit consumers by increasing the number of carriers selling long-term care insurance products, expanding the type and number of products available to consumers, reducing the time lag between product filings and product availability in the market place and lowering the costs of products. Furthermore, the broadening of competition in the market place would act as a powerful incentive for insurance companies to offer high quality, competitively priced products.

2. Section 2321(b) - Uniform Terms (p.435)

The Health Security Act would require insurers to use uniform terminology, definitions of terms, and formats in long-term care insurance policies.

HIAA recognizes that in order to provide meaningful benefits, policies must have clearly understood and well defined long-term care benefits. Several policy benefits, however, cannot be uniformly defined at this time. States vary widely in their definitions of licensed long-term care providers. Many types of noninstitutional services are evolving and there is no clear, much less uniform, definition developed. Beneficiaries could be harmed if definitions are "locked in" prematurely.

An example of the difficulty in having uniform definitions of terms pertains to assisted living facility benefits. Different states and provider organizations use different criteria in defining assisted living facilities. The type of services provided in these settings may range from meals and housekeeping only to assistance with personal care. Regulations regarding the type of licensed or nonlicensed personnel required to provide services in these settings differ across states. Yet both of these care settings may be referred to as "assisted living."

HIAA believes that it is important to maintain flexibility in defining certain terms in long-term care policies. This would allow companies greater latitude in offering a variety of benefits under long-term care insurance policies as both the insurance market, and the continuum of long-term care services, continue to evolve.

3. Section 2321(c) (2) (D) - Premium Limitations (p. 437)

Under the standard outline of coverage for long-term care policies, carriers would be required to include a statement of the total annual premium and the portion of such premium attributable to each covered benefit; and any limit on annual premium increases.

HIAA strongly supports reasonable and justifiable insurance premiums which ensure that a carrier's long-term care obligations will be met. We share the Administration's concerns that consumers be protected from unwarranted rate increases. To that end, we believe the most effective protections include measures which assure that initial premiums, and potential increases, are determined appropriately on the basis of actuarial data. However, we oppose the establishment of arbitrary limits on premium increases and do not believe that such limits would achieve the goal of ensuring that rates are set correctly in the first place. In addition, such limits have the potential to threaten insurers' abilities to pay future claims which is certainly not in the best interest of consumers.

To assure that consumers are protected against unfair rate increases, and to promote the establishment of accurate rates at the outset of premium pricing, HIAA recommends the following measures be taken:

- * Prohibit insurers from selling policies with premium schedules based on attained age rating and durational rating.
- * Require insurers to report their total long-term care premiums earned, claims incurred and loss ratios by state and in total to each state annually to provide states with the data needed to accurately assess the viability of premium pricing assumptions and methods.
- * Require state insurance departments and the NAIC to develop and specify minimum standards for establishing long-term care reserves to ensure that adequate resources will be available to pay all claims.
- * Require insurers to meet an expected loss ratio of at least 60 percent for individual policies. In addition, the NAIC, working with the industry, should determine the effects of lapse rates and underwriting practices on the pattern of loss ratios.
- * Require insurers to provide rate guarantees for three years from the date policies are issued. In addition, rate increases should be limited to 10 percent for insureds over age 75 who have maintained coverage for 10 years or more.
- * Require carriers to provide insureds the opportunity to reduce the level of benefits covered under the policy 90 days prior to a rate increase. This would enable consumers to maintain premium levels no higher than those in effect prior to a rate increase.
- * Implement sanctions against insurers who demonstrate excessive rate increases. HIAA recommends that in cases where carriers increase rates by more than 50 percent in any three year period, they should be prohibited from issuing policies for a period of two years in the state where rates were increased in excess of this limit.
- * Permit state insurance commissioners to modify or waive rate provisions which could jeopardize solvency. For example, rates may need to be modified in the event of changes to federal and state laws or based on medical breakthroughs or new disabling diseases that would result in changes to mortality and morbidity patterns or assumptions.

4. Section 2321(c) Comparative Coverage (p. 440)

Under the outline of coverage, carriers would be required to provide consumers with comparative information regarding the availability of other private insurance including benefits offered under other long-term care policies offered by the insurer; additional benefits available under policies offered by other private carriers; and information regarding each public long-term care program administered by the state, Medicare programs under title XVIII of the Social Security Act and each regional alliance operating in the State.

HIAA supports the right of consumers to receive accurate and thorough disclosure which enables a prospective insured to accurately assess the benefits and limitations of long-term care insurance coverage. We also support requirements that insurers provide consumers with a state-approved long-term care insurance consumer guide; the address and phone number of the state insurance department with the name and number of an insurer home office contact; and, if such a program exists, the name, address and phone number of a state-approved senior insurance counseling

program. This information should be provided at the time of policy solicitation.

HIAA is concerned, however, about requirements to provide additional information required under the Health Security Act, such as information about competitors' insurance products and detailed information about federal and state public programs, including benefits available under regional alliances. These reporting requirements are excessive, burdensome and, quite frankly, unachievable by any private or public sector entity.

5. Section 2324(d) Agent Compensation (p.448)

Directs Secretary of HHS to establish limits on agent compensation.

HIAA does not support the use of agent compensation restrictions. We believe that problems with regard to lapse rates and replacement rates should be dealt with more directly by regulating agent sales and marketing practices and extensive agent training and education. Caps on commissions will not remove incentives for unwarranted initial sales or ill-advised policy replacements. Blanket restrictions on sales commissions do not distinguish between agents selling in an ethical, responsible way and those who do not. The job of regulators is, and should continue to be, the effective enforcement of laws designed to weed out and prevent abuses -- not the creation of laws which indiscriminately restrict appropriate competition across the board.

Long-term care insurance is still a relatively new market around which a great deal of consumer ignorance and misunderstanding still exists. The sale of this product involves educating consumers about the need for long-term care protection, the service options available and individual product options. Dedicated agents should not be penalized for spending the extra time necessary to assist consumers in understanding their long-term care needs and options.

6. Section 2326(b)(2) - Independent Professional Assessment (p.463)

This section would provide for an independent assessment of benefit eligibility by a qualified independent assessor selected by the insured.

HIAA objects to an independent third party determining eligibility for private policies. While we advocate that there be a strong appeals process, the insurer, or an organization affiliated with the insurer, is contractually obligated to manage an individual's long-term care needs so that the best care can be delivered most efficiently. Transferring the claim adjudication function to an outside party could expose the insurer to unintended claim liabilities.

7. Section 2325(e) - Mandatory Nonforfeiture (p. 457)

This section would mandate nonforfeiture benefits.

HIAA supports the concept that insurers must be required to offer all prospective policyholders, including group policyholders, a nonforfeiture benefit in the event of non-payment of premium. This should bear a reasonably consistent relationship by issue age and duration. We do not support mandated nonforfeiture benefits in policies because of the resulting premium increases associated with this benefit and questions regarding the value this benefit to those required to purchase it. HIAA also disputes the validity of the reasoning behind a mandate for nonforfeiture benefits. Nonforfeiture benefits presumably are

needed due to high lapse rates among long-term care insurance policyholders. Yet data collected by HIAA regarding lapse rates indicates that 50 percent of so called lapses are due to deaths and internal or external replacements; i.e., consumers replacing existing coverage with a newer policy offered by the same carrier or with a policy offered by a different carrier.

A mandatory nonforfeiture benefit presents serious equity problems because it would substantially increase premiums for the majority of policyholders. An HIAA analysis based on data prepared for the NIAC indicated that, for a cohort of policyholders, only 30 percent would benefit from a reduced paid-up nonforfeiture benefit. The other 70 percent would be forced to pay additional premiums, but never receive any benefit. According to an HIAA analysis of several of its members' long-term care products, a reduced paid-up nonforfeiture benefit increased the average annual premium for a 55 year old by 30 percent and, for a 60 year old, 20 percent. A nonforfeiture benefit which returns premium upon lapse raised the average annual premium for all ages by roughly 40 percent.

HIAA also questions the value of nonforfeiture benefits relative to the costs, and whether this strategy is the most effective vehicle for addressing the problem it is intended to cure -- voluntary lapse of insurance policies. Like life insurance, long-term care policies must be in force for a certain period of time before substantial benefits would accrue to the lapsed policyholder. Since most consumers who let their policies lapse do so in the first two years of coverage, there would be no value, -- only cost -- to requiring nonforfeiture benefits. Policyholders who maintain their policies would not need nonforfeiture protection. Finally, if educated consumers fully understand the benefits and limitations of nonforfeiture, they should be given the option to purchase such protection.

HIAA feels that a more appropriate solution to the problem of policy lapses is to assure that consumers understand the need for and value of long-term care insurance protection, make educated choices about the purchase of products and that agents are well-trained to assist consumers in making prudent choices. HIAA supports agent education and includes such provisions in our Consumer Protection proposal. We also support the establishment of consumer education grants as specified in the Health Security Act.

8. Section 2346 - Failure to Have Approved State Program

This section would prohibit insurers from selling policies in a state that does not have in effect an approved state regulatory program.

HIAA objects to this provision which would penalize insurance carriers and consumers for state violations of federal law. HIAA recommends that carriers be permitted to sell in any state as long as their products comply with minimum federal standards. Such a policy would encourage carriers to comply with minimum federal standards regardless of state implementation and enforcement activities. It would assure consumers access to a wide range of products that meet minimum federal standards.

III. TAX CLARIFICATION

HIAA applauds the President for including tax clarification in his health care reform proposal. The current uncertain tax treatment of long-term care insurance is a hindrance to market acceptance and raises the price of the product. Clear tax rules will add legitimacy to, and further the establishment of, the long-term care insurance market. The expansion of this market

will have the parallel effect of reducing future costs to the public sector.

We also are very pleased that the Administration's proposal contains provisions which clarify the tax status of life insurance policies that accelerate benefits on account of terminal illness and long-term care. Since accelerated benefits were introduced in the early 1980's, we have sought clarification of the federal tax issues surrounding these products, which are now offered by more than 150 insurers and owned by approximately three million policyholders. As a result of this clarification, policyholders will be able to utilize their life insurance policies without adverse tax consequences to assist them in dealing with extraordinary medical expenses.

HIAA also supports the provision of tax credits for employed persons with disabilities. This provision would enable impaired taxpayers to take a non-refundable tax credit equal to 50 percent of certain impairment-related personal assistance services.

HIAA agrees with most of the tax clarification provisions in the President's bill. There are, however, a few items which HIAA feels the Committee should modify. The first is the list of activities of daily living (ADLs). The President's bill proposes using eating, toileting, transferring, bathing and dressing in order to qualify for tax treatment. The industry would suggest either the inclusion of incontinence, or the substitution of incontinence for either bathing or dressing. Generally, if an individual can not dress, he or she also can not bathe, and vice versa. Essentially, bathing and dressing are the same ADL. This is not true of toileting and incontinence. The effect of using the list including bathing and dressing is earlier qualification for benefits and a higher revenue loss for the Treasury.

If Congress intends to establish a standard of requiring 2 out of 5 ADLs, then it should eliminate either bathing or dressing, and substitute incontinence, which is much more widely used in the industry. Alternatively, the Committee could add incontinence to the list and allow companies to choose which five ADLs to specify in their contracts.

Second, HIAA feels that the maximum benefit amount excluded from taxation of \$150 per day beginning in 1996, indexed for inflation, is too low. In many areas of the country, particularly large urban centers, \$150 is insufficient to cover the costs of nursing home care. HIAA would suggest that the maximum benefit amount be set at \$250, indexed for inflation, to assure that consumers who live in higher cost urban settings are not penalized based on geographic location.

There are a number of other changes that HIAA would suggest. While the Health Security Act creates a level playing field among different types of long-term care policies, it treats long-term care insurance benefits as accident and health benefits rather than as disability payments under Section 105(c), as the industry would prefer. Section 105(c) covers payments related to the loss of bodily function. This criteria is closely related to the inability to perform ADLs and, therefore, more consistent with the eligibility criteria used in most long-term care insurance products.

Many states now require companies to use a one-year preliminary term reserve. However, the IRS permits companies to deduct reserves no faster than over a two-year period. HIAA feels Congress needs to conform the tax code to state regulatory requirements.

Many companies now permit covered employees to enroll their parents under their plan. To help encourage this trend, HIAA

recommends, for the purpose of long-term care insurance payments, that parents be treated as dependents.

Finally, the effective date of many of the tax clarifications in the Health Security Act is December 31, 1995. HIAA sees no reason it could not be sooner, perhaps December 31, 1994, to help consumers afford protection as quickly as possible.

IV. NEW HOME AND COMMUNITY BASED SERVICE PROGRAM

HIAA has two concerns with the newly proposed national home care program. First, we believe that a far better use of limited tax dollars would be to target care to those unable to protect themselves. Scarce federal and state resources should be preserved for the needy rather than promising all Americans a small amount of coverage. Individuals who can afford to purchase private insurance coverage should be encouraged to do so through education and tax incentives. Educational programs, such as those that would be available under the proposed consumer education grants, should assist consumers in understanding the risk of catastrophic long-term care expenses and options for covering this risk. Tax incentives should be used to increase the affordability of long-term care products. Furthermore, the establishment of tax incentives would lend additional legitimacy to long-term care products and increase consumer confidence in such products.

Second, HIAA questions the viability of this new community-based service benefit and is concerned that there is great potential for consumers to misconstrue their right to this benefit and overestimate the amount of protection afforded under this program. Our primary concern regarding the viability of this program relates to funding. Even this modest benefit is projected to cost \$65 billion and funding for the program is contingent upon extremely ambitious projections regarding costs savings under current federal programs -- including \$65 billion in new Medicaid savings.

HIAA also believes that there is great potential for the public to misunderstand the coverage provided. Although the legislation does not provide an entitlement to this new benefit, there is ample evidence of public misperceptions regarding federal long-term care benefits. To wit, the 1993 EBRI long-term care survey indicates that a higher percentage of respondents to this survey (45%) thought that Medicare would pay for their long-term care expenses than respondents to EBRI's 1990 survey (35%) -- despite the tremendous media attention to the long-term care problem in recent years.

Further, HIAA does not believe that the funding allocated to this program will provide substantial coverage for home care services to a broad segment of the population. Since income caps and age limitations are removed, we believe that many more individuals will qualify for benefits than states will have funding to cover, even under the enhanced federal match rate. In addition, while the program is targeted toward the severely impaired, HIAA is concerned that the public will not understand the eligibility limitations placed on the program and will overestimate the coverage provided. In the absence of broad-based public education, it is extremely likely that consumers will underestimate their ongoing need for private coverage of these services.

HIAA also is concerned that the structure of this program will lead to confusion among consumers regarding their coverage. The program calls for the use of both public and private financing to cover the same home and community-based services. Until an individual is severely disabled, their community-based services would be financed under a private insurance policy. Once they

became severely disabled, they would discontinue private coverage and begin receiving public benefits for these services. Receipt of public benefits, however, would be contingent upon the availability of state funding for these services. Furthermore, except in the wealthiest states, such as New York, it is questionable whether consumers would receive the same level of community-based benefits under the new public program as they would have received under their private insurance policy. In such cases, the consumer might need to maintain the private insurance policy to supplement the cost of services not provided under the public program.

The structure of the new home care program hardly creates the kind of "seamless" system touted by the Administration. To the contrary, it creates the potential for tremendous confusion on the part of consumers. It also presents challenges to insurance companies attempting to structure a private insurance benefit that coordinates with public coverage. If each state has the discretion to establish its own benefit package for home and community-based services, insurance carriers will need to develop a different home care benefit for every state to coordinate with public benefits. Furthermore, to maintain currency with state programs, carriers would have to update their home care benefits each time states modified their programs, restructure premiums to account for changes in actuarial assumptions and pricing, and refile new products with state insurance departments.

HIAA is concerned that the administrative and financial burdens placed on carriers under the Administration's proposed program structure would force carriers to reconsider the viability of offering home care coverage. Surely, this is not in the best interest of consumers who consistently have expressed their preference for this type of coverage in national surveys. For these reasons, HIAA strongly recommends that eligibility for the new home and community-based service program be income-related and that private insurance be encouraged for those who can afford this coverage.

CONCLUSIONS

HIAA applauds the President for introducing an ambitious blueprint for reform of our nation's health care delivery and financing system. We further are encouraged that he recognizes the need to address long-term care in his vision for reform through the establishment of a strong public/private partnership in long-term care financing. Clearly the magnitude of the financing dilemma suggests the need for such a partnership to ensure access to long-term care services for all Americans.

HIAA believes that our current long-term care financing system can best be enhanced through three strategies. Individual responsibility in planning for long-term care risk must be promoted through education. The development of a strong private long-term care insurance market can be facilitated through tax incentives that increase the affordability of long-term care products and lend legitimacy to this market. Federal standards, in conjunction with tax clarification, can further increase consumer confidence in long-term care products and spur market growth. Finally, for those who are unable to finance their own long-term care services, a humane program of public assistance must be provided.

HIAA is pleased that the Administration has included several provisions in The Health Security Act which are consistent with HIAA's goals and strategies for promoting long-term care protection. These provisions include clarifying the tax status of long-term care products; establishing federal minimum standards; authorizing consumer education grants for long-term care information and counseling; and amending the Medicaid program to allow for higher asset thresholds and by raising the personal needs allowance for the institutionalized.

The Health Insurance Association of America would like to serve as a resource to Members of Congress and the Administration in refining proposals to improve our country's system for financing long-term care services. We stand ready to assist the Committee in this process in the coming months.

We believe that the Health Security Act is an excellent beginning.

Chairman STARK. Mr. Garner, are you familiar with the average amount of life insurance that Americans hold today?

Mr. GARNER. No, I am not.

Chairman STARK. If I told you it was less than \$10,000 a person, would you be surprised?

Mr. GARNER. Yes, I would. I would have assumed that people would have more, especially when you include life insurance through their employer's group life insurance plan.

Chairman STARK. They do, but it is probably close to 7 or 8. You want to make a guess as to maximum cash value that would be in a \$10,000 policy—even if it were \$9,000; right?

Mr. GARNER. I would guess it would be something like a fourth of the face value.

Chairman STARK. About \$2,500, maybe.

Now, you are familiar with life insurance sales practices, all the way from the Ed Beeman to a CLU. You are aware of what goes on in the world, and you are aware that Prudential keeps insuring, even though they keep stealing money from the investment customers trying to convince you that they are safe and they go on selling insurance.

It is a relatively intensive skills sophisticated sales operation, is it not?

Mr. GARNER. Yes, it is.

Chairman STARK. And the best they have been able to do is \$10,000 for an event that we all know will happen. People are dying to get into the life insurance benefits. So what leads you to think that—we have heard testimony that people are going to need long-term care in the amount of \$30,000 a year.

The average life insurance value that can pay benefits out of is only around \$2,500. What leads you to believe that people are going to rush to buy enough long-term care when we can't sell them enough life insurance? By any estimate, people are probably underinsured. And I am going to suggest to you that life insurance for people under 65 is probably a lot more desirable, and has a lot more emotional impact, than long-term care.

We all know that we are going to die. Or to take care of estate taxes or take care of a widow or an orphan. What leads you to think that this is going to have a broad market appeal?

Mr. GARNER. A couple of factors. One has been the dramatic growth in the purchase of long-term care insurance policies over the last 5 years or so. If we were sitting here 10 years ago, we would have seen that there was not even much of a long-term care insurance industry at all. And we now see that almost 3 million policies have been sold.

The annual growth rate is 20 percent on the individual policy side between 1987-92, but more dramatically over the last year, there has been an 82 percent increase in the number of individuals who have purchased long-term care through their employers. That is a time when the product is much more affordable for individuals. So those signs are encouraging.

Chairman STARK. Would you oppose a nonforfeiture benefit for people who hold their policies for more than 2 years?

Mr. GARNER. Let me clarify something on the nonforfeiture. We support a system where all companies would have to offer nonforfeiture.

Chairman STARK. Come on. No insurance regulator in their right mind would let you out not covering nonforfeiture benefits in a life contract. It is in the law because insurance companies overreserve that people are getting a good deal.

I am suggesting would it ease your problem—you are saying you get a high lapse ratio in the first 2 years, 50 percent; right?

Mr. GARNER. If I could point out one other thing. All life insurance is not required to have nonforfeiture values. There are forms of insurance such as term insurance—

Chairman STARK. But even term insurance. If it is a level premium, there is even nonforfeiture in that. It is a function of the reserves that are held. It is disingenuous to say that if there are those reserves, that every State in the union requires nonforfeiture with the exception of some term products which have no reserves to speak of.

Go back for a moment, now, in just—you did say that you get a 50 percent lapse ratio in the first 2 years. I think that is on page 15.

Mr. GARNER. No, if it says that, it is in error. The typical lapse rates for long-term care policies are something like 8½ percent, but that would even include people who die while they held the policy. So the actual lapse rates are about 6 percent per year. I think the numbers—if you compared that to Medicare—

[The following was subsequently received:]

I believe you misread our written testimony. We state that 50 percent of lapses are due to either internal replacements, external replacements or death.

Chairman STARK. What is it the first 2 years?

Mr. GARNER. I think the point that we tried to make in the testimony is that the lapse rates are higher in the first couple of years after a policy is sold than what they are in later years.

Chairman STARK. That is right. So what are they in the first 2 years?

Mr. GARNER. I would say they average something like 10 percent and then they grade down to much smaller numbers in later years.

Chairman STARK. Would you have an objection to having a mandatory nonforfeiture benefit after the first 2 years?

Mr. GARNER. After the first 2 years?

Chairman STARK. You get your selling costs back.

Mr. GARNER. No. Our position is that we should not be required to have that, but that it be offered to every individual.

Chairman STARK. Let's assume for a minute that you are required to do that and you are required to have an inflation amount, what is your average—let's just pick a person, 50-years-old or if there is an age at which you more often use an illustrative age. Is there one?

Mr. GARNER. Age 50 would be good.

Chairman STARK. At age 50—without any nonforfeiture benefits and with an optional benefit—without any benefit for inflation, what does a policy run?

Mr. GARNER. At age 50, it would probably cost about \$400 or \$500 per year.

Chairman STARK. Per year?

Mr. GARNER. Per year; right.

Chairman STARK. Now if we require nonforfeiture benefits and we required mandatory inflation at the 5 percent figure that you stated what would that same policy have to sell for, keeping the same commission rates and expense ratios?

Mr. GARNER. I don't have the numbers, but I would estimate that it would be about \$1,250.

Chairman STARK. So to do the right thing you double it from \$800 to \$1,000 a year?

Mr. GARNER. Yes.

Chairman STARK. That would cover about what?

Mr. GARNER. That would cover inflation protection.

Chairman STARK. What kind of a benefit package would you get for either the \$400 to \$500 or the \$800 to \$1,000 depending on—

Mr. GARNER. Nursing home care at \$80 per day, \$40 per day home care, 4 years of coverage, 20-day elimination period, nonforfeiture benefit, and inflation protection at a rate of 5 percent compounded.

Chairman STARK. For how long?

Mr. GARNER. Indefinitely.

[The following was subsequently received:]

For inflation protection, the daily benefit amount would be compounded at a rate of 5 percent annually.

Chairman STARK. Indefinitely. It would pay a third to a quarter of the cost so that to insure yourself adequately you should figure a \$3,000 or \$100 a day, you would have to kick that up a little bit, wouldn't you, you would have to get 20 percent more coverage on that. OK.

Do you have any figures on the income range of the people, your current customers in the industry? You are suggesting that public assistance could provide for those unable to finance their own.

I am wondering at what income level you would suggest that people be purchasing their own and you might indicate if you know at what income level the majority either—some income level above which 80 percent of your sales occur. Can you tell me that?

Mr. GARNER. I can give the committee some figures that we developed in a study last year. It is true that past sales tended to be at higher income levels because those are the individuals who find the product at older ages to be most affordable. But the encouraging thing that we have seen with each passing year is that the average age at which sales are made is decreasing, and I know in our company the average age of sales is now age 65 and is moving into preretirement years.

Chairman STARK. I am just wondering what the average gross income level is of the purchaser.

Mr. GARNER. As I say, we can provide you detailed information.

[The following was subsequently received:]

Income Status of Individual Purchasers *

(In percent)

Income	Percent of total purchasers
Less than \$20,000	29
\$20,000 to \$34,999	33
\$35,000 to \$49,999	17
Greater than \$50,000	21
Total	100

* HIAA Survey.

Chairman STARK. You don't have one in mind? Would you say that mostly it is people over \$50,000 a year? Can you get me within a—

Mr. GARNER. No, no, a substantial amount of the sales are probably, say, greater than \$30,000.

Chairman STARK. Greater than \$30,000. You would say 80 percent of it over that?

Mr. GARNER. Yes.

[The following was subsequently received:]

About 70 percent of policies were sold to persons with incomes above \$20,000.

Chairman STARK. What I am trying to find out is at what point you are going to cede this market to the Federal Government because you are not selling enough, and you are going to say it is for individuals with \$30,000, maybe \$50,000 family income; that that is your market?

Mr. GARNER. One of the problems is I don't think that is clear at this time. We are at the very early stages of the development of this market, and we really have not had time to find out what level of income people would purchase this at. One of the problems we have is that the public—

Chairman STARK. Are you suggesting that you guys have done no market surveys of who—

Mr. GARNER. No, what I am suggesting is—

Chairman STARK. You are just not going to share them with me.

Mr. GARNER. No, what I am suggesting is that as people become more and more aware of the issues of long-term care, and we have heard that earlier this morning that a lot of people just aren't aware of the risks that they face for long-term care, they are becoming increasingly so every year.

As people become aware of that, I think people will recognize that they are willing to devote a larger portion of their income or their assets to long-term care protection.

Chairman STARK. Does your company sell medigap or supplemental insurance for Medicare?

Mr. GARNER. No, we do not.

Chairman STARK. You don't? Thank you.

Mr. McDermott.

Mr. McDERMOTT. No questions.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Well, I take it from your testimony, from your response to Mr. Stark, and your testimony on page 5, that you disagree with the first witness this morning who said selling properly structured long-term care policies to the nonelderly in large numbers will be extremely difficult. You basically disagree with that?

Mr. GARNER. I am sorry, on what, page 5?

Mr. LEVIN. Of Josh Wiener's testimony, where it says selling properly structured policies to the nonelderly in large numbers will be extremely difficult. You obviously disagree with that?

Mr. GARNER. Well, I think we disagree on the proportion of the elderly that we will ultimately be able to reach. I know Mr. Wiener has done some modeling that would indicate that maybe 20 percent of the population would be willing to spend 5 percent of their income. I think what we see as the greatest opportunity for the private long-term care market is through group insurance and through selling products to employees of an employer at an early age when the prices are much lower.

[The following was subsequently received:]

An HIAA study estimates that 42 percent of the current elderly population can purchase a private long-term care insurance policy. And because premiums for long-term care insurance are based on age at time of purchase and remain level over time, the proportion of younger elderly able to afford a policy is higher.

Table 2

Eligible Elderly Market for Long-Term Care Insurance

Age group	Percentage ineligible based on:				Total percentage qualifying
	Income & asset	Disabled in nursing home	Disabled in community	Total combined*	
65 to 74	46%	1%	7%	50%	50%
75 to 84	54	6	10	62	38
85 and up	82	21	24	92	8
Weighted total	52	5	10	58	42

* The total percentage ineligible reflects the overlap of those not qualifying because of income, assets, and health status

Sources: LifePlans estimates; 1982 and 1984 National Long-Term Care Surveys; 1985 National Nursing Home Survey; Income of the Population Age 55 and Over; and Survey of Income and Program Participation.

I think we do see problems in trying to sell individuals at older ages who have waited until they are age 70 or 75 when the cost is very high. It may be difficult to provide coverage to a high proportion of the population in that age group.

Mr. LEVIN. What should be done vis-a-vis those people?

Mr. GARNER. Well, I think what the situation that we are in now is that we have to rely on the three elements that we spoke of earlier, encouraging as many of those people as can purchase it to buy private insurance, including encouraging savings and individual responsibility, and also providing a government program, primarily through an expansion of Medicaid, that would care for individuals who have not financed that on their own.

Mr. LEVIN. But if there is going to be a government program that covers people, elderly people who have not financed their own, what basic stimulus is there for people when they are younger to buy the coverage?

Mr. GARNER. Currently I think many individuals purchase long-term care coverage because they do feel a very strong sense of individual responsibility. That is the number one reason that purchasers of long-term care list when asked for the reason they purchased the product.

Mr. LEVIN. But they also know there isn't presently a very adequate program if they become elderly and they don't have coverage, they have to be pretty poor to be covered, so I assume a basic motivation as to why people purchase long-term care when they are 30, 35 is because of a fear they won't have it when they are older, no?

Mr. GARNER. Well, what they state is that they want to prepare—to be able to pay for long-term care expenses on their own if they need them.

Mr. LEVIN. Because they won't otherwise be available?

Mr. GARNER. I can't say that. I don't know if that is what their thinking is.

Mr. LEVIN. I mean there is a dilemma here, isn't there? If there is going to be an adequate program for those who aren't covered, what is the financial stimulus for people when they are younger to purchase it? If we don't have an adequate program for those who are elderly, what do they do? So let me just—give me the bottom line.

We probably won't be able to call each other on it, but if we go the way we are with some restructuring, some government controls so that there is a more level playing field and more information and some of the abuses are weeded out.

Seriously, what is your guess as to the number of people who would be covered with an adequate long-term care policy when they reached 65?

Mr. GARNER. When they reach age 65? I think—I have not modeled that, and what we would have to do is model it well out into the future and make assumptions as to the popularity of employer-employee programs because that is the area where the private insurance industry has the greatest opportunity to contribute, to pick up a big share of the liability, but I cannot estimate the number of people who would be covered.

Mr. LEVIN. Is that a relevant issue?

Mr. GARNER. I think that is a relevant issue, and I think that making a determination of the part of the—the share of that burden that private insurers would be able to pick up is something that we need to do. Right now we are in the infancy of this whole market so it is difficult to predict exactly how much progress we will be able to make.

Group insurance plans, for example, have only been available for 2 or 3 years. On the acute health care side, insurers have been selling health insurance for 50 years. For long term care, we are in the first few years of a developing market. It is very difficult to predict where it is going to go. My point is that it is much too early to give up on the private insurance market.

Mr. LEVIN. Thank you.

Chairman STARK. Is it fair to say that as an actuary that the risk selection in long-term care is somewhat more random than other types of insurance?

Mr. GARNER. Well, I don't know if random is the right word. Again, insurance companies are experimenting at this point with what the right risk selection criteria are.

Chairman STARK. They are not as comfortable as they are, say, in life insurance or in health care where they have had a lot of experience, is that a fair assumption.

Mr. GARNER. That is very true.

Chairman STARK. Make the case for me, if you will, in a minute or two why we should have restrictions that are any less rigorous on nonforfeiture benefits on long-term care than we do on life insurance.

Mr. GARNER. It is most important to give consumers the choice of whether or not to pay for something that is that expensive, and what it amounts to is adding another approximately 40 percent on to the bill that they would have to pay for long-term care. At a time when affordability is such an important issue in trying to establish the private market, we feel that we should give people the option whether or not they want to increase their bill by 40 percent.

What we find is that when we give people the option on inflation protection, for example, we find that consumers choose very wisely. At younger ages where inflation protection is most critical, in our company over 90 percent of the people buy inflation protection, but at higher ages where they are nearer to the time when they will use the benefit, when they have a better understanding of what they will be able to pay, only about 15 percent purchase that benefit. I am glad we don't mandate inflation protection when there is such a wide disparity there in the choices of people.

Chairman STARK. But you admit there it makes good sense from a consumer's standpoint? I mean, it is a wise decision to have it?

Mr. GARNER. I think for younger people inflation protection is a very wise decision, yes, and I find that they choose wisely.

Chairman STARK. So let's get back to why is the life insurance industry—and you are asking us to make nonforfeiture benefits optional for the insurance. It wouldn't sell, would it?

Mr. GARNER. I think largely it is for historical reasons that they haven't made them optional in the United States. If I understand it correctly, Canada has the option. In Canada, you are not required to have nonforfeiture values in all life insurance products.

Chairman STARK. But haven't we had to tighten up on some of the investment products recently on back-end fees and that sort of thing just because of abuses? There is always a bad apple in the barrel, but you know, these things happen. I think that the same abuses that the regulators attempted to prohibit in life insurance could be in this. If you think it is good for a young person to protect themselves against inflation, you would be disloyal to every CLU in the world if you didn't say that the great argument for whole life is that it will protect you for yourself.

We know that you might cancel your term insurance, but on the cash value—that is the litany, is it not, of the salesmen, that the reason you don't save money at the bank is because you don't have that premium to force you there. I can't get a really good sense that says, wait a minute, we should have it—the reserve issue is pretty much identical in both cases. I think it is the right thing because although admittedly their premium will increase, they get absolutely nothing back, and for a small increase in premium should they have a change in their financial condition or should they come a cropper with an insurance salesman who is less than completely ethical, at least they will get some money back to start over or to provide some assistance. By the same token I think you have trouble making the argument if you really feel they ought to have inflation protection that I would think the same reasoning goes that they ought to have some nonforfeiture benefits.

It might result they won't take cash they will just take a lesser benefit for life, it pays so long, you start when you are 45, you get to be 70 and you really are short, you could take a continuing benefit rather than just lose it all. What I see coming is what happens to the person who gets that when they are really just about there, and they are climbing the mountain and then they slip.

I just find from a consumer protection situation, by the same, making the right decision, that that ought to be there. It is fair to say it is to the financial advantage of the insurance company not to have it.

Mr. GARNER. Well, I could clarify one point about that. The financial advantage does not really accrue to the insurance company itself. It accrues to the benefit of persisting policyholders.

Chairman STARK. OK. All right. It could be if they, in fact, pass it on. Now you are talking about that insurance company that takes every bit of savings and passes it through to the policyholders rather than to its shareholders?

Mr. GARNER. Right.

Chairman STARK. I have my torch out looking for that insurance company. The same thing is true of the insurance companies who sell securities, right?

Mr. GARNER. Right, but insurance companies are required to pay back a certain portion of every premium dollar, and those standards must be met for products that do have nonforfeiture and also ones that do not.

Chairman STARK. What do you think is right? About 90 percent would be about right for long-term care?

Mr. GARNER. Typically for individual policies, it is 60 percent or higher.

Chairman STARK. So you would say a 90 percent minimum loss ratio would be about right?

Mr. GARNER. No. I think 90 percent would be much too high for the way products are distributed today.

Chairman STARK. Well, we could distribute them some other way. The insurance agents wouldn't like that very much, but—thank you very much.

Our third panel consists of five witnesses representing home health provider organizations: Val J. Halamandaris, who is president of the National Association for Home Care; Carol Raphael who is chief executive officer of the Visiting Nurse Service of New York; James C. Pyles, who is a principal of powers, Pyles and Sutter, representing the National Home Health Services Alliance; and Sam P. Giordano, who is the executive director of the American Association for Respiratory Care.

Welcome to the committee. Mr. Halamandaris, why don't you lead off.

STATEMENT OF VAL J. HALAMANDARIS, PRESIDENT, NATIONAL ASSOCIATION FOR HOME CARE

Mr. HALAMANDARIS. Thank you, Mr. Chairman.

With your permission, I would like to enter my statement in the record and summarize for you briefly.

Chairman STARK. Without objection.

Mr. HALAMANDARIS. We would like to commend the President and the First Lady for a remarkable job and historic piece of legislation that they have put forward. We also would like to commend the chairman of this committee, Mr. Stark, and Mr. McDermott for the leadership that you have shown in the Congress.

I commend both of you for what you have done. You have provided the moral leadership that has been necessary to put this issue on the front burner and the American people are going to soon benefit from your many, many years of efforts.

We would like to support the President's plan as introduced. We believe there are a number of key elements in that plan, and it will provide for the first time a measure of security for the American public. I used to think I knew a lot about health care and about long-term care until I traveled the country in a bus as I did this summer. I spent about 3 months traveling country and went in every State. The bus traveled 16,000 miles around the country and to each of your States and every major city what we heard from the American public is that the American public overwhelmingly is tired of a system that does not include everyone, the American public wants a system that covers all 37 million uninsured, and the most crucial problem that pops up again and again is the long-term care.

As the chairman pointed out, there are approximately 10 million people out there that need help with long-term care and that are not getting help and assistance. Those numbers are only going to grow as the chairman alluded to by the year 2030 we are talking about approximately 20 million people who will need help with long-term care and assistance.

The problem will be crucial. If it is not addressed now, it will come back and haunt us in much larger form. As the First Lady

has pointed out to us, there is no way to control health care costs if you do not cover long-term care. Therefore we think it is crucial that this be an element of the final package that is enacted.

I have been around a long time, helped write some of the Medicare-Medicaid legislation way back in the 1960s, and remember again and again we have made the decision to defer covering long-term care for a variety of reasons, and in retrospect it has proven to be a mistake, so we would like to commend the President and the First Lady for including long-term care as an integral part of the President's plan and those of you at the dais, the chairman and Mr. McDermott, for your bills and for the emphasis you placed on long-term care.

There are a couple of elements in the President's plan that concern us. One of those elements is the effort to restrict Medicare and cut back Medicare by \$124 billion. As I said in a letter to the President, Mr. President, it is impossible to make a new covenant with the American public by breaking an existing covenant. You are saying to the Medicare beneficiaries that we are going to cut your entitlement by \$124 billion and give in return some billions of dollars back. That raises the question of whether they are better off or they are worse off.

As you heard a while ago, people are not sure. So we are troubled by that fact.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF VAL J. HALAMANDARIS
PRESIDENT
NATIONAL ASSOCIATION FOR HOME CARE**

My name is Val Halamandaris. I am President of the National Association for Home Care (NAHC), which represents the nation's home care providers -- including home health agencies, home care aide organizations, and hospices -- and the individuals they serve. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all individuals who require them. Toward this end, NAHC has long advocated the development of a national plan to ensure universal access to basic acute care and long-term care services.

NAHC believes that no health care proposal is complete without ensuring access to high quality home care and hospice in both the acute and long-term care setting. These vital services provide millions of individuals -- the aged, infirm, disabled, and children -- the ability to receive care in the settings that allow them the highest level of satisfaction, independence, and dignity -- in their homes.

REFORM PLANS MUST ADDRESS NEED FOR LONG-TERM CARE

Any action taken on health care reform must not overlook the growing need in the U.S. for a comprehensive long-term care program. It is impossible to separate the need for reform of the current health care system from addressing the need to include a long-term care component.

Long-term care is one of the most devastating problems America faces today. Estimates indicate that between 9 and 11 million Americans of all ages require long-term care because of chronic illness or disability that render them helpless to perform basic tasks of daily living without assistance. This number could double by the year 2030 to more than 19 million. The need for long-term care is expected to increase substantially as a result of several factors: the burgeoning growth of the elderly population; increased usage of high technology and new medical breakthroughs that may extend the lives of more mentally retarded, developmentally disabled and physically disabled persons; increased survivorship of low birthweight children; greater longevity for children with terminal chronic illness, and earlier detection of chronic health problems; and the growth of the number of persons with AIDS.

Spending for long-term care is currently estimated at \$57.8 billion. Yet neither Medicare nor private insurance provides adequate protection against the costs of long-term care. Many families exhaust their emotional and financial resources providing and purchasing long-term care. A million Americans a year go bankrupt trying to meet the cost of long-term care left uncovered by insurance. Only the most wealthy of Americans are insulated from the potential financial devastation. The rest can have their lifetime savings wiped out in a matter of months paying for long-term care.

Long-term home care improves the quality of life because it is more humane. It reinforces and supplements the care provided by family members and friends and maintains the recipient's dignity and independence, qualities that are all too often lost in even the best institutions.

Long-term home care services can also be cost-effective. New York State's experience with its Nursing Home Without Walls program is that the great majority of clients who would otherwise need to be placed in a nursing home can be cared for at home for a much lower cost.

Medicaid waiver programs have increasingly relied on home care services as a way to reduce states' long-term care costs. For example, New Mexico's waiver program for people with AIDS estimates a savings of \$1,100 a month for patients who use home care rather than skilled nursing facility care. The average patient plan of care costs \$1,000 a month for home care compared to \$2,100 a month for skilled nursing facility care, according to the program director. Moreover, New Mexico reports that only about 47 percent of patients receiving waiver services are hospitalized in a given year, compared to 70 percent of those not under waiver.

The National Governors' Association (NGA) has recognized the importance of home care services and in a resolution adopted in 1992 stressed the importance of making home- and community-based services a key component of all long-term care policies and programs. NGA recommended elimination of the current institutional bias in public programs for long-term care in favor of home care as a more preferred and cost-effective method of care.

PRESIDENT'S PLAN WOULD ESTABLISH HOME-BASED LONG-TERM CARE PROGRAM

The President's health care reform proposal would establish new federal programs for long-term home care services that would be run by the states and provide additional expansions and improvements in Medicaid long-term care programs. The significance of these provisions cannot be overemphasized. Millions of Americans now go without needed long-term care or are forced to impoverish themselves to qualify for minimal Medicaid coverage.

The President's plan also contains two important provisions that the National Association for Home Care has strongly supported over the years. First, the plan would permit disabled Americans who are under age 65 to qualify for these desperately needed home- and community-based services on the same basis as the elderly. Second, the plan would not require states to use costly external case management procedures that duplicate standard caregiver activities. Third, access to benefits would not be based on income. However, the plan would apply a copayment schedule based on clients' income levels.

The federal government would provide most of the funding for the new long-term home care program and establish minimum eligibility and benefits guidelines. States would administer the program and contribute an amount of funding roughly equal to their current spending on long-term care for the severely disabled. Federal spending on this new program is expected to total \$57 billion in the first five years and \$38.3 billion a year when fully implemented in the year 2003. To qualify for benefits under the new program, an individual would have to need assistance in performing at least three of five specified activities of daily living (bathing, dressing, transferring, toileting, eating). Individuals who have severe cognitive or mental impairment, or individuals who have severe or profound mental retardation could also qualify. In addition, individuals under the age of six who are dependent on technology and who would otherwise require hospital or institutional care would be eligible for services.

At a minimum, states would be required to include coverage for personal services for assistance with activities of daily living. States would have the flexibility to provide other home- and community-based services such as homemaker and chore assistance, respite services, and adult day care services.

State Medicaid programs would back up these programs for the severely disabled by providing home- and community-based services for low income individuals with fewer than three ADL deficiencies. Medicaid would also continue coverage for low income individuals who need nursing home care. Enhancements to the Medicaid long-term care program would include: (1) an increase in the personal needs allowance from \$30 to \$70 a month; (2) an increase in the level of protected assets from \$2,000 to as much as \$12,000, at the option of the state; and (3) states must set financial eligibility at a point that is no lower than SSI eligibility.

The proposal would establish federal standards and tax preferences for private long-term care insurance policies. The federal standards would not require minimum benefit packages but would require private long-term care insurance plans to: base eligibility for services on functional ability; provide nonforfeiture features (e.g., require a portion of premiums to be refunded when policies terminate); provide inflation protection, and meet additional consumer protection standards. Plans that meet these standards would qualify for tax deductions for policy premiums paid by individuals and employers.

Additional tax incentives would be established to support certain disabled individuals who work. For example, employed individuals who require assistance with activities of daily living and who purchase personal care and personal assistance services could obtain tax credits for up to 50 percent of their costs, up to a maximum of \$15,000 per year.

NAHC COMMENTS ON PRESIDENT'S LONG-TERM HOME CARE PROGRAM

The National Association for Home Care applauds the President's commitment to providing needed long-term care to the millions of Americans with chronic disabilities. This crucial component of the Health Security Act will help make the promise of health care for all a reality for the young, the elderly, and all disabled Americans.

We especially applaud the President's reliance on home care as the foundation for this new federal long-term care program. Home care has a long and distinguished history of caring for individuals of all ages in the setting they like best -- in their own homes where they can maintain their dignity, their independence, and their individuality.

NAHC has several concerns regarding the President's plan that we think should be carefully considered. First, of primary importance is that the program should be adequately and realistically funded. The promise of long-term home care will not become a reality until real funding sources are proposed to meet the needs. The President's proposal uses massive new Medicare cuts, along with an excise tax on cigarettes for the long-term care program.

NAHC is opposed to the proposed cuts in the Medicare home care benefit contained in the \$124 billion in proposed Medicare cuts. Home health care has already been hit hard by administrative cutbacks in the Medicare cost limits and this year's reconciliation bill, and the proposed new cuts could seriously jeopardize patient access to care. We hope Congress will choose not to enact such deep and imposing cuts in the Medicare program. In addition, cost estimates show that revenues from the cigarette excise tax are expected to diminish over time.

Both the near-term and long-term revenues for the long-term home care program are somewhat in doubt. NAHC strongly believes that funding for a long-term care program should be broad-based and progressive, and reliable for many years to come.

A second concern is that the Administration's proposal may not meet the needs of all Americans in need of long-term care. Primarily due to financing pressures, the Administration has chosen to limit the program to individuals with limitations in three or more activities of daily living (ADLs). This is indeed a very needy population, but it leaves on the sidelines a large and growing number with limitations in two or fewer ADLs who are equally in need of care. It is important to note that an individual unable to carry out even one ADL can be extremely disabled and in need of long-term care. For example, an elderly individual, living alone with no family or other caregiver close by, who needs assistance with only one ADL, such as eating, would benefit greatly from a relatively small amount of long-term home care.

We understand the need to begin new programs conservatively, but we hope that the Administration will work to provide long-term care to all those in need within a reasonable timeframe.

A third issue of concern to home care providers is that of case management. The President's long-term proposal would allow all qualified entities, including home care agencies, to perform case management functions. We support this permissive language that would enable each state to choose case managers for their programs. Many home care agencies perform these important functions today and resist the notion that only a separate additional agency can correctly perform important case management functions. Outside case management, in many cases, does little more than increase administrative costs and layers of bureaucracy that are placed between patients and providers.

Finally, NAHC is concerned that health care reform plans use adequate quality assurance mechanisms. The use of outcome-based mechanisms is at this time little more than a theoretical possibility. Until such mechanisms are available, NAHC recommends the requirement of standards for organizations delivering in-home skilled services can be found in the Medicare Conditions of Participation for home care and hospice. For nonskilled service providers, suitable standards can be based on the requirements developed by the Joint Commission on Accreditation of Healthcare Organizations, the Community Health Accreditation Program and the National HomeCaring Council, which have developed special standards for training, testing and supervision of paraprofessional workers employed by home care aide organizations. These provider standards serve as important protections for consumers.

The President's plan also allows eligible individuals to independently contract and supervise home care aides. While there are a limited number of cases where this may be appropriate, the vast majority of individuals eligible for services under the long-term home care program should receive services from qualified home care agencies. In cases where independent providers are used, the legislation should ensure that they are appropriately trained, tested, and supervised as well as provided with basic employee benefits -- including health care coverage -- and other support.

SUMMARY

Inadequate access to acute health care and long-term care is the single most devastating problem facing America. And this problem will only get worse unless prompt action is taken. Reform legislation must address the need for access to both basic health care coverage, including home care and hospice services, and a comprehensive array of long-term care services based on home care.

Without federal reform, health care costs will continue to increase while access to basic services and long-term care services deteriorates. Congress should make the most of the current climate of support for change and make health care reform a top priority for action next year.

The President's proposal represents a paradigm shift away from federal coverage for care in the home setting. We are excited and optimistic about the potential for this landmark change. The National Association for Home Care looks forward to working with the Administration and Congress toward enactment of a health care reform plan that will contain the increases in health care costs while achieving universal access to high quality care.

Chairman STARK. Ms. Raphael.

STATEMENT OF CAROL RAPHAEL, CHIEF EXECUTIVE OFFICER, VISITING NURSE SERVICE OF NEW YORK

Ms. RAPHAEL. Thank you.

Good afternoon, Mr. Chairman and members of the subcommittee. I also would like to enter my statement in the record and briefly summarize my points.

The Visiting Nurse Service of New York is the largest not-for-profit home health agency in the United States. This year we are celebrating our 100th birthday. We provided last year 1½ million hours of professional and 11 million hours of paraprofessional services to 70,000 diverse patients in New York.

I want to make a few points. The first is that the need for long-term care is great. As has been indicated, it is now in the range of 10 million Americans who need the care, and that is expected to double by 2030. But more importantly, long-term care affects all of us. A Gallup Poll in 1993 indicated that one out of every five Americans in the last 5 years has had an experience with long-term care, either directly or because of a family member's illness.

Second, that need for long-term care is currently not being met. The Medicare program does not provide custodial care, the Medicaid program requires people often to impoverish themselves and has a bias toward more costly institutional care, and we have also heard today about the long-term care private insurance market and the low number of Americans who are able to afford it.

I think the goals for any long-term care component of health care reform have to be identical to what we are trying to do with health care reform overall, and that is to give people security and try to put in incentives to manage the cost over the long term.

I think from my point of view, from a provider of long experience there are three key principles that are currently embodied in the President's proposal that ought to be retained.

The first is making home and community care the centerpiece of any long-term care plan. Why do I say that? I think most people may not realize how flexible home and community-based care is. In New York City, we have been able to expand the system because of the AIDS epidemic. We currently serve every day 10 percent of the AIDS case load in New York City, and we are doing that at a phenomenally low cost compared to what it would cost were all those people to be hospitalized.

Hopefully the AIDS epidemic will not be here at the same level in 10 years, and then the system can shrink. We haven't built institutions that are hard to dismantle. In addition to that, we also believe that this is a situation where consumer choice is congruent with what is really affordable, and most people overwhelmingly prefer home and community-based care and it generally costs less.

Second, we really believe that eligibility should not be based on age. It should be based on functional disability levels. Forty-eight percent of the people we take care of are under 65.

Last week I visited a little girl named Jennifer whom we take care of who is 8-years-old who has seizure disorder. Her parents are really determined to keep her out of an institution, and they are in charge of her suctioning, her nebulizer, et cetera. It costs

\$200 a week for us to have a nurse go in and enable them to do that, and I think it is really important to recognize that we take care of people who have had car accidents, swimming pool accidents, who have multiple sclerosis, who have Lou Gehrig's disease, people of all ages who also are in need of long-term care.

Third, we endorse the President's proposals attempt to try to balance two difficult things, which is to give the States flexibility and to set some minimum standards for any plan. I come from the State of New York. That State has made a deep commitment to home and community-based care, and I think any future system should recognize that and try to build on it and allow every State to tailor its program to the unique needs of its residents.

I think that there are some important elements that need to be taken into consideration in going forward. The first is that we believe that providers need to have flexibility in setting up comprehensive systems of care. We are currently experimenting with a Medicare managed care program called the Community Nursing Organization in which we are going to provide care under a capitated rate. We are setting up an adult day care program that may also be a rehabilitation center. It will be a place for people to get a whole array of services as well as socialization.

There are many comprehensive models that should be supported because people's needs change. Someone who has a stroke may need a high level of care 1 day and 3 months later, a very different level of care, and I think as we construct this new system we have to allow great flexibility for providers as well as consumers to give people the right care at the right time.

Last, I know Congressman McDermott spoke about the whole issue of block grants, and is this the best way to deal with the financing problem and the precarious nature of previous block grant arrangements. We believe that there are other ways to deal with the financing elements. There are other ways to hold providers and consumers accountable for dollars spent.

I think one of the things that makes long-term care different from any other part of the health care system, if you can call long-term care currently a system, is that most of the care is being provided by family, friends, neighbors, members of the community. I think that as we fashion the system, we have to figure out how to allow that care to continue and not to build a system in which we replace that care but rather we should try to supplement it.

I would conclude by saying that I think we also need to build a system that integrates long-term care with acute care. Every Friday we bring about 400 people home from New York City hospitals, and if we didn't do that, those 400 people would remain in those hospitals over the weekend for no good reason. They want to go home and are ready to go home. The whole system and availability and consumer access to long-term care is inextricably linked to how we create an acute care system in this Nation.

Thank you. I look forward to working with this committee to ensure that home and community-based, long-term care remains part of health care reform, and we build the best possible system for the next century.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF CAROL RAPHAEL
CHIEF EXECUTIVE OFFICER
VISITING NURSE SERVICE OF NEW YORK**

Mr. Chairman and Members of the Subcommittee, I am Carol Raphael, Chief Executive Officer of the Visiting Nurse Service of New York. I appreciate the opportunity to appear before you today in order to discuss the importance of making long term care a part of health care reform, and to describe the pivotal role that home care plays in long term care.

Celebrating its 100th year of service this year, the Visiting Nurse Service of New York -- VNS for short -- has an unwavering commitment to meet the health care needs of individuals, such as the frail elderly, AIDS patients, and the inner-city poor.

As the nation's largest non-profit home health agency, VNS made almost 1.5 million professional visits and furnished over 11 million hours of paraprofessional service to more than 70,000 patients in 1992. Serving an extraordinarily diverse patient population in New York City, VNS has substantial experience in successfully developing and implementing a wide array of home care programs to meet both people's short-term acute and long-term chronic care needs. Our long experience demonstrates that home health care is cost-effective in treating a wide range of illnesses and health problems. Moreover, VNS's experience vividly illustrates that home health care is infinitely flexible in its ability to adapt to the changing needs of diverse patient populations. It can respond quickly to new technology and changes in clinical practice to meet patient needs which previously required institutional care.

THE NEED FOR LONG TERM CARE

Long term care is generally defined as medical, nursing, social, and personal care services provided in the home or an institution for an extended period of time to patients with severe chronic illnesses or disabilities that render them unable to perform basic tasks of daily living without assistance.

The profile of the person in need of long term care is diverse, although two-thirds are over 65 years old. It includes, for example, the elderly person with severe diabetes, coupled with high blood pressure and a history of strokes; the young child with asthma; the young adult accident victim who is paraplegic or quadriplegic and ventilator-dependent; the father who has suffered a stroke; the person with Alzheimer's Disease; the elderly woman who fractured her hip; the young man with AIDS.

It is widely estimated that between 9 and 11 million people of all ages are in need of long term care services today. It is projected that by the year 2030, this figure will almost double. This growth is primarily a result of: (1) the burgeoning of the elderly population (which, according to the General Accounting Office will reach 18% of the total population by 2030); (2) increased use of technology and new medical breakthroughs that will continue to extend the lives of the disabled and chronically ill; and (3) the entrance over the last few decades of millions of women into the workforce, many of whom are no longer available to take care of family members at home.

Furthermore, long term care is something which affects not only the disabled and chronically ill -- it affects all of us. A 1993 Gallup Poll sponsored by the Employees Benefit Research Institute found that over the past five years, 21% of those surveyed had experienced long term care needs either for themselves or for family members.

While it is clear that the need for long term care is great and will continue to grow, the availability of coverage and funding for long term care is limited. Medicare does not cover custodial services that constitute a large portion of

long term care services. Medicaid coverage of long term care varies widely by state, but in most states, the focus has been on institutional care, and relatively few home-based long term care services are covered. In addition, to obtain such Medicaid coverage, people must first spend their resources down to the federal poverty level, forcing impoverishment in order to qualify for the care covered under Medicaid. Finally, private health insurance for long term care covers only about 1% of today's elderly. Families USA recently found that 4 out of 5 Americans between ages 55 and 79 cannot afford private long term care insurance.

There is thus an increasing need, but an insufficient availability of long term care services. It is, of course, possible to separate the need for reform of the current acute care health care system from the need to establish coverage of long term care. However, reform plans that are limited to acute and primary care fall far short of solving the health care crisis in America.

The great challenge before the Congress is to devise a plan which gives security to the chronically ill and disabled, but which also controls the utilization and cost of long term care. Based on VNS's vast experience in providing varied home care services, we believe that there are a number of critical principles that should be reflected in any long term care proposal. We now present these principles and how the President's health care reform proposal stacks up against them:

PRINCIPLES FOR CRAFTING A LONG TERM CARE PLAN

- I. **HOME AND COMMUNITY-BASED CARE SHOULD BE THE CENTRAL FOCUS OF ANY LONG TERM CARE PROGRAM.** We commend the President for making home and community-based care the linchpin for his proposed long term care benefit. This focus is essential for the following reasons:

- A. Home care enables people to maintain their independence in the community and avoid costly institutionalization. For example:

Maria R. is a 99-year-old woman who has had a stroke and has some weakness on her left side. She has an in-dwelling urinary catheter, which needs to be changed every month by a visiting nurse. She has a son who lives nearby, who is himself an elder adult. He assists in her care, but he would not be able to manage it alone. Without the visits of the nurse, Maria R. would be in a nursing home, where she does not want to be, and which would be far more expensive.

- B. Home care is cost-effective, since it flexibly responds to America's changing health care needs without the capital expense of "bricks and mortar." Home care generally is less expensive than hospitalization or institutionalization. For example, home care has been demonstrated to save \$7,000 per month for a chemotherapy patient, and \$78,000 per case for victims of catastrophic accidents.

As an example, VNS, in its average daily census last year of 1,500 AIDS patients, served 50 who participate in its At Home Options Program (AHOP) for Empire Blue Cross Blue Shield subscribers. A study indicated that those participating in AHOP incurred \$5,068 less for inpatient admissions, and \$720 less in outpatient institutional claims, than those who did not participate.

- C. Americans prefer home care. Studies have consistently shown that Americans overwhelmingly prefer being cared for at home, since it appeals to their powerful desire for autonomy and privacy. People generally heal and recover more quickly and comfortably at home.

II. THE LONG TERM CARE BENEFIT SHOULD NOT BE AGE-BASED.

Rather, it should cover not only those over age 65, but disabled persons under 65 as well. VNS is very pleased that eligibility for the President's proposed new home and community-based long term care program is based on an individual's level of functional disability as measured by the need for assistance in activities of daily living, as well as certain other measures of severe disability.

As VNS's current caseload demonstrates, patients in need of long term care services are found in all age groups, with widely varying diagnoses and service needs. For example:

- A. Eight year old Jenny C. has been diagnosed with seizure disorders and bronchial asthma. She and her family have been receiving respite care from VNS for the last 7 years, which takes the form of one to three nursing visits a week. Jenny is totally dependent upon her mother to take care of her daily care needs include tube feedings, nebulizer treatments, suctioning, turning and positioning, and monitoring and providing her numerous medications and special food. Were it not for the relief provided to her mother through this relatively small amount of nursing service, which allows her to rest and to leave the house, Jenny's family would be forced to institutionalize her at a much greater financial and emotional cost.
- B. We now serve 1,500 AIDS patients every day, more than any hospital in New York City, and fully 10% of New York's AIDS caseload. This AIDS caseload, while predominately male, includes increasing numbers of women and children. As these patients become sicker during the course of their illness, VNS provides a full array of home care services, including "high-tech" infusion therapies.

III. IN ORDER TO ASSURE THAT LONG TERM CARE BENEFITS CAN BE INTEGRATED INTO STATES' HEALTH SERVICE SYSTEMS, STATES SHOULD BE GIVEN FLEXIBILITY TO CRAFT THEIR OWN BENEFITS PACKAGE AND SERVICE MODELS SUBJECT TO CERTAIN MINIMUM STANDARDS.

Any long term care benefit which is part of national health care reform should establish coverage for a minimum set of services which would apply uniformly across the country. States, however, should be given flexibility and actually should be encouraged to offer long term care services which are tailored to the needs of the residents of those states. Importantly, states which have already taken action to be responsive to the long term care needs of their residents should not be disadvantaged or penalized under long term care reform.

New York State, for example, has for many years made a strong commitment to long term care, and in particular has made an investment in home care as an integral part of the long term care continuum. It has developed a unique system which includes a wide-range of provider types in order to be able to creatively meet individuals' long term care needs. We believe that any health care reform initiative should acknowledge the ability of a state such as New York to fashion a plan of its own, building upon the strengths of its experience.

An example of innovation is New York State's heralded "Nursing Home Without Walls" Program, of which VNS is the largest provider. This is a home-based alternative to institutionalization for frail and functionally-dependent elderly individuals, with reimbursement capped at 75% of the cost of nursing home care. I thought a patient vignette would be instructive:

Mr. B. is a 77 year old diabetic man with an unstable medical condition including high blood pressure and a history of strokes, who requires ongoing monitoring, supervision and care by a nurse, home health aide and nutritionist. Through this program, we are able to maintain him in his own home, where he prefers to be, and prevent re-hospitalization -- with his care costing approximately \$2,000 a month, as opposed to \$5,000 a month for nursing home care.

We believe that the President's proposed new home and community-based long term care benefit tries to strike a balance between minimum uniform requirements and state flexibility. The plan would establish coverage for a modest minimum set of services -- assessment, care plan development, and personal assistance services but would allow states to offer a much wider range of services.

- IV. **IN ORDER FOR CONSUMERS TO HAVE ACCESS TO THE LONG TERM CARE SERVICES THEY NEED, PROVIDERS SHOULD HAVE THE FLEXIBILITY TO PROVIDE THE FULL SPECTRUM OF LONG TERM CARE.** Currently, this country suffers from a fragmented delivery system which often makes it difficult for individuals in need of long term care services to obtain them. Providers should be encouraged to design flexible models of care which allow consumers, based on their needs at a particular point in time, to be appropriately served at home, in the community, or in an institution. In other words, we need models with interchangeable parts which can be added or removed based on the patient's condition and choice of care.

VNS currently is experimenting with several models of care that incorporate but go beyond home care. For example:

- A. Under contract with the Health Care Financing Administration, VNS currently is designing and implementing a Medicare managed care program, known as the Community Nursing Organization, for 1,000 Medicare beneficiaries. This is a capitated nurse-managed program in which nurses act as gatekeepers for a package of benefits that includes home care and several ambulatory care services.
- B. VNS also is working with officials of New York State to develop a capitated long term care program for Medicaid clients. As part of this program, we anticipate providing some nursing, rehabilitative, and personal care services in congregate settings such as an adult day care center. For some clients, adult day care is a cost-effective way to deliver the same services provided by home care agencies with the added benefit of socialization.

Over time, this program will resemble the innovative "On Lok" program in San Francisco, which enables severely disabled, older people, who would otherwise be in nursing homes, to remain at home. The program is funded through the use of Medicare and Medicaid funds to provide enrollees with acute and long term care services under a fixed monthly rate.

There is some controversy over what role case management should play in the spectrum of long term care services, and who should provide it. We believe that the long term care spectrum should include case management services for those individuals with complex needs. It is VNS's view from its long experience that not all patients require case management services and to require such services for all beneficiaries will add cost without any benefit. There are, however, a class of beneficiaries for whom case management services are critical for assuring effective provision of quality services.

It is VNS's experience that home care providers have long been successful as cost-effective coordinators and managers of health care and social support services for those complex-need patients, since they are close to the community and the people they serve. Therefore, where case management services are required, home care providers should be allowed to be case managers. Home care providers such as VNS currently provide a full array of services to patients in the home and community, including nursing, therapies, paraprofessional services and social work, and are responsible for working with patients' family members, the physician and the community to ensure safe and effective care at home.

VNS is concerned that the long term care plan presented by the President could exacerbate, not ameliorate, the fragmented nature of the existing "system". VNS understands that, to contain expenditures, there may need to be varying eligibility criteria for different packages of services. We are concerned, however, about creating a patchwork of state-administered programs for long-term care. The proposed structure suggests that the individual consumer may face substantial obstacles when seeking long term care services. VNS urges that long term care reform efforts facilitate the development of a coordinated long term care system.

- V. **ANY LONG TERM CARE REFORM PLAN NEEDS TO INCLUDE COST CONTAINMENT FEATURES.** VNS recognizes that there are legitimate concerns about the costs and potential open-endedness of a new long term care benefit. We believe that creation of a national home and community-based long term care benefit is long overdue. Nevertheless, we understand that a modest beginning may be necessary. VNS commends the President for taking an important first step in addressing the needs of the chronically impaired head-on.

There are various ways to control utilization of long term care services and expenditures, such as restricting eligibility, limiting the aggregate number of dollars spent on long term care services, limiting expenditures per beneficiary, establishing beneficiary copayments, and formulating provider reimbursement methodologies which place the provider financially at risk and thereby encourage the cost-effective and efficient delivery of services. In addition, states should be encouraged to integrate the fragmented elements comprising long term care -- Medicaid, Medicare, the aging network, conflicting regulatory requirements -- into a better coordinated, more cost-effective long term care system.

One of the challenges facing long term care is how to obtain a better understanding of its real cost, and how to control its potential growth over the coming years. There currently is a lack of empirical evidence to show, for example:

- 1) The extent to which long term care costs are now accounted for in the cost of acute care, and how this affects projections of the real cost of both acute and long term care;
- 2) How to integrate "formal" care of health care providers with the network of "informal" care provided by families, volunteers, and philanthropic organizations, and in doing so not undermine incentives to families and other informal supports to continue providing service; and
- 3) How to keep states, health plans, and providers accountable for controlling the cost of service.

To get answers to these and other questions, we believe it is necessary to make funding available for research and demonstration projects in which these issues are studied and analyzed. VNS has recently established a research center in recognition of the need to have a better understanding of the costs and effectiveness of home, community and long term care.

VNS's expertise in this area centers on developing innovative programs for meeting the long term care needs of groups of beneficiaries which involve creative payment methodologies. Increasingly, VNS is negotiating with a variety of third-party payers to provide packages of home care services on a capitated rate basis. As provided for in the President's proposal, we believe that it will be important for states to have the flexibility to establish various payment methodologies for long term care services.

As a direct service provider, VNS has little direct experience with "macro" cost control measures such as the President's proposed national cap on home and community-based service expenditures. Should such a cap be politically necessary, VNS urges that it not be implemented in a way which would disadvantage states such as New York that have been leaders in meeting the long term care needs of their residents and that presumably would want to be able to cover services in excess of the national minimum.

CONCLUSION

It is fitting that the Clinton health reform plan is called the "Health Security Act". Surveys and polls have repeatedly shown that the elderly have an overriding concern about their long term care needs. We believe that the President's plan represents an attempt to address this essential component of America's health care system.

Furthermore, the central role assigned to home and community-based services and their providers is appropriate not only because it is flexible and cost-effective, but most important, because it is what Americans want.

Again, I appreciate the opportunity to share the views of Visiting Nurse Service of New York with you, and would be pleased to answer your questions.

Chairman STARK. Mr. Pyles.

STATEMENT OF JAMES C. PYLES, COUNSEL, NATIONAL HOME HEALTH SERVICES ALLIANCE

Mr. PYLES. Mr. Chairman, Mr. McDermott, I am James C. Pyles. I am appearing on behalf of the National Home Health Services Alliance, which is a coalition of all types of home health service providers and includes representation from three national and many State home health associations.

Participants of the alliance applaud the efforts of the President and the subcommittee to address the issue of health care reform. We believe that crucial public policy decisions will have to be made, and it is more important to see that they are made correctly than it is to make them quickly.

We also applaud the President's proposal to offer coverage of long-term care based principally on home care, but we urge him and you to remember that home care is first and foremost an indispensable acute care service.

As we stated at the hearing before this subcommittee in April, home care offers the best opportunity to further the twin objectives of health reform, providing increased access to health care while controlling the costs. As laudable as the President's proposal is for furthering the health care reform debate, the proposal in our view contains several fundamental flaws.

First, the proposal contains inconsistent limitations and illogical disincentives for the use of home care. The long-term care portion of the President's proposal properly acknowledges the cost-effectiveness of and patient preference for noninstitutional care by making home and community-based services the core benefit.

In the acute care portion of the proposal, however, home care is covered "only as an alternative to inpatient treatment in a hospital, skilled nursing facility or rehabilitation facility after an illness or injury."

Ironically there is virtually no limitation on the coverage of inpatient hospital services. Thus, the least limitation is placed on the most costly setting. This is an incentive we believe that is running in the wrong direction. It would seem far more logical to limit coverage of inpatient hospital services to cases where home care and other lower cost treatment settings are not medically safe and cost-effective alternatives and to permit coverage of home health services as long as they are medically necessary as currently provided under the Medicare program.

Further, we believe there should be no 20 percent coinsurance required for home health services as currently contemplated by the higher cost sharing option of the President's proposal. Such coinsurance amounts will not generate significant revenue because home care only accounts for approximately 2.6 percent of all national health care expenditures.

Those coinsurance amounts, however, will discourage patients from obtaining the home health care they need, thereby necessitating other more costly care. Home health services should be regarded in our view like preventive services, services related to prenatal care, and case management services for which under the

President's plan no coinsurance is required, since all of these services help patients to avoid other more costly care.

Second, the President's proposal ensures that consumers will have their choice of provider for long-term care, but fails to provide similar assurance for the acute care portion of the bill. Already "merger mania" has been reported sweeping through the health care industry with nearly twice as many acquisitions occurring as of October as occurred in all of last year. All three hospitals in Portland, Maine, have announced plans for a consolidation which, according to a refreshingly candid spokesman, would result in the hospitals "locking up the entire market." This is the wave of the future unless measures are taken to preserve competition.

The nature of a reformed health care system will depend on whether it is based on competition or on regulation. Accordingly, whether competition will be preserved could be the single most important issue Congress has to face. If Congress adopts a health reform plan that permits reduction or elimination of competition through establishment of government sanctioned monopolies, the government and consumers will lose all control over the system.

The only alternative then will be to tightly regulate monopolies like utilities. We do not believe that quality, cost-effectiveness, and innovation can be promoted or preserved as well by regulation as by competition. There can be no competition where there is no choice and there can be no choice without market access. Thus, market access and consumer choice are two sides of the same competition coin whether for long term or acute care services.

We have listed a number of points in our testimony which I will just touch on just quite briefly which we believe must be in any health care reform bill.

First, competition must be preserved at the provider as well as at the health plan levels. Consumers must be offered a choice of providers where possible and providers must honor that choice.

Health reform legislation should expressly state that none of its provisions should be construed as permitting monopolization, attempted monopolization, conspiracy to monopolize or other restraint of trade which is prohibited under the antitrust laws.

States should be prohibited from limiting or preventing competition among providers to participate in a health plan by any anti-trust exemption or otherwise.

Providers and other health care organizations seeking protection of a safe zone established by guidelines published by the Department of Justice and the Federal Trade Commission should contemporaneously publish a notice in a local newspaper of general circulation generally describing the nature of the project.

Finally, I would just mention that equal opportunity to demonstrate one's merit and the right of citizens to choose based on that merit are core principles of our economic and political systems.

It is appropriate on this Election Day when these rights are being exercised across the country that we reaffirm our commitment to them by ensuring that they are included in any health reform legislation.

Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

**STATEMENT OF JAMES C. PYLES
NATIONAL HOME HEALTH SERVICES ALLIANCE**

Mr. Chairman and members of the Subcommittee:

I am James C. Pyles, and I am appearing on behalf of the National Home Health Services Alliance, which is a coalition of every type of home health service provider and which includes representation from three national and many state home health associations.¹

Members of the Alliance applaud the efforts of the President and the Subcommittee to address the issue of health reform. We believe that crucial public policy decisions will have to be made and that it is more important to make them correctly than to make them quickly. While the current health care system clearly needs reform, it is possible to make it worse instead of better if Congress acts precipitously and without listening to the concerns of providers and consumers.

We also applaud the President's proposal to offer coverage of long term care based principally on home care, but we urge him and you to remember that home care is first and foremost an indispensable acute care service. We commend the President's plan for including the points we made at the April 22 hearing before this Subcommittee, that health reform legislation must (a) include home care as a basic acute care benefit, and (b) establish the basic benefit package by statute rather than through an unelected and unaccountable board.

As we stated at the April hearing, home care offers the best opportunity to further the twin objectives of health reform -- providing increased access while controlling costs. Home care utilization grew at an annual rate of 10% between 1986 and 1991 and is estimated to grow at an annual rate of 12% from 1991 to 1996.² Yet, home care expenditures grew at an average annual rate of only 5% between 1986 and 1991.³ Thus, the rate of increase in the cost of home care is already at the level the President hopes to achieve for all health care services.

Laudable as the President's proposal is for furthering the health reform debate, the proposal contains several fundamental flaws.

First, the proposal includes inconsistent limitations and illogical disincentives for the use of home care. The long term care portion of the President's proposal properly acknowledges the cost effectiveness of, and patient preference for, non-institutional care by making home and community-based services the core benefit. See Health Security Act, § 2104. In the acute care portion of the proposal, however, home health care is covered "only as an alternative to inpatient treatment in a hospital, skilled nursing facility, or rehabilitation facility after an illness or injury." See § 1118(b). Ironically, there is virtually no limitation on the coverage of hospital services. See § 1111(b). Thus, the least limitation is placed on the most costly service setting.

It would seem far more logical to limit coverage of inpatient hospital services to cases where home health care and other treatment settings are not a medically safe and cost effective alternative and to permit coverage of home health services as long as they are medically necessary, as currently provided under the Medicare program.

Further, there should be no 20% coinsurance required for home health services as currently contemplated by the higher cost sharing option of the President's proposal. See §§ 1133(10) and 1135. Such coinsurance amounts will not generate significant

¹ Participating organizations include the American Federation of Home Health Agencies, the Home Health Services and Staffing Association, and the Visiting Nurse Association of America.

² "Basic Statistics About Home Care 1993" at 3, National Association of Home Care.

³ *Id.*

revenues because home care only accounts for about 2.6% of all national health care expenditures.⁴ They will, however, discourage patients from obtaining the home health care they need, thereby necessitating other more costly care. Home health services should be regarded like preventive services, services related to prenatal care, and case management services, for which no coinsurance is required, since all of these services help patients avoid other, more costly care.

Second, the President's proposal ensures that consumers will have their choice of providers for long term care but fails to provide similar assurances for acute care. See § 2102(a)(2)(D). Already "merger mania" has been reported sweeping through the health care industry with nearly twice as many acquisitions occurring as of October as occurred in all of last year.⁵ All three hospitals in Portland, Maine have announced plans for a consolidation which, according to a refreshingly candid spokesman, would result in the hospitals "locking up the entire market."⁶ This is the wave of the future unless measures are taken to preserve competition.

The nature of a reformed health care system will depend upon whether it is based on competition or on regulation. If Congress adopts a health reform plan that permits the reduction or elimination of competition through the establishment of government sanctioned monopolies, the government and consumers will lose all control over the system. The only alternative then will be to tightly regulate the monopolies like utilities.

We do not believe that quality, cost effectiveness, and innovation can be preserved or promoted as well by regulation as by competition. There can be no competition where there is no choice, and there can be no choice without market access. Thus, market access and consumer choice are two sides of the same coin of competition.

Integrated health care delivery systems may provide some advantages, but they should not be permitted to suppress competition through monopolization, and patients should have the right to select their provider based on quality and cost effectiveness rather than on corporate affiliation. If it is sound public policy to prevent physicians from steering patients under the Medicare and Medicaid programs to health care companies they own, then health care organizations should be prohibited from engaging in similar conduct.

There is rapidly growing concern that many of the health reform proposals, including the President's, do not adequately preserve market access and consumer choice. At a meeting held in Washington on October 26, representatives from 26 provider and consumer associations registered these concerns. Congressman Jim Cooper has recognized some of the concerns raised by these organizations and has included language in the Managed Competition Act of 1993 (H.R. 3222) to enhance the opportunity for market access and patient choice. Similar language was included in a companion bill introduced by Senator John Breaux (S. 1579).

The need to preserve competition is partially, though not entirely, an antitrust issue, therefore, it is appropriate to raise before this Subcommittee. Accordingly, we urge you to vote for no health reform plan unless it contains the following features:

⁴ *Id.*

⁵ "Health-Care Firms Face Checkup for Merger Potential," The Wall Street Journal, C1 (Oct. 12, 1993).

⁶ "Hospital Plan in Maine Tests Antitrust Law," The Wall Street Journal, B1 (Aug. 25, 1993).

1. Competition is preserved at the plan as well as at the health plan levels.
 - (a) Providers in "health plans" or "AHPs" must be selected by a competitive process which utilizes objective criteria including quality, price, and patient satisfaction.
 - (b) A description of any competitive selection process and the criteria to be used must be published and made available to interested providers upon request sufficiently prior to the selection determination to permit all interested providers a fair opportunity to participate. (This does not necessarily imply that "any qualified provider" must be allowed to participate, but simply that participation determinations must be based on known, objective criteria.)
 - (c) Participating providers should be evaluated periodically under the participation criteria, and an "open season" must be provided at least every two years during which non-participating providers will have an opportunity to demonstrate that they can fulfill the selection criteria better than the participating providers.
2. Consumers must be offered a choice of providers, where possible, and providers must honor that choice.
3. Health reform legislation should expressly state that none of its provisions should be construed as permitting monopolization, attempted monopolization, conspiracy to monopolize or other restraint of trade which is prohibited under the Sherman Act (15 U.S.C. §§ 1-8), the Clayton Act (15 U.S.C. §§ 12, 14-27; 29 U.S.C. § 52), or the Federal Trade Commission Act (15 U.S.C. §§ 41-58).
4. States should be prohibited from limiting or preventing competition among providers to participate in a health plan by any antitrust exemption or otherwise.
5. Providers and other health care organizations seeking protection of a "safe zone" established by guidelines published by the Department of Justice and the Federal Trade Commission must contemporaneously publish a notice in a local newspaper of general circulation generally describing the nature of the project.
 - (a) The rationale for the foregoing provision is two-fold:
 - (1) those seeking an exemption from enforcement of the public policy expressed in the antitrust laws should be required to provide at least some notice to the public, and
 - (2) interested parties should have some limited opportunity to alert the Department of Justice and the Federal Trade Commission to local market conditions which may be material to their determination.

Chairman STARK. Mr. Giordano.

**STATEMENT OF SAM P. GIORDANO, EXECUTIVE DIRECTOR,
AMERICAN ASSOCIATION FOR RESPIRATORY CARE**

Mr. GIORDANO. Thank you, Mr. Chairman and Mr. McDermott, for the opportunity to highlight key points contained in our testimony.

Since respiratory care is not necessarily a household word, I would like to first describe their role in the health care delivery system. Respiratory care practitioners provide for patients of all ages—infants to the elderly. They work with individuals that have underdeveloped lungs, and they also work with individuals that have chronic ailments, such as emphysema, bronchitis, and asthma.

Patients who are dependent on medically complex mechanical ventilators to breathe for them are also cared for by respiratory care practitioners. We are, by the way, the only allied health profession which is educated, trained and tested in the treatment and diagnosis of these critical lung problems.

We applaud your efforts and those of your colleagues in Congress as well as the President to reform health care, yet we think you should be aware of some severe inequities in any health plan that bases its respiratory coverage policies on Medicare. Patients needing to receive respiratory care services on a long-term care basis would be impeded from doing so.

Current Medicare benefits do not provide access to respiratory care services outside the hospital. Many privately insured patients have access to respiratory care services in long-term care venues because it has been found to be cost efficient. Studies have shown that the respiratory care benefit, when added, saves more than it costs by decreasing the rate of hospital admissions as well as shortening length of stay in acute care facilities.

If the reform package is passed without such a benefit, more beneficiaries would therefore have to use the hospital in order to gain access to respiratory care services which they presently receive as part of their current coverage.

If the reform package is passed with the benefit, then we could count on less utilization of hospital admissions and length of stay because Medicare beneficiaries as well as the younger patients would therefore be allowed to access this important form of long-term care.

We encourage you to include respiratory care services as part of the long-term care benefit package. It makes good sense from a quality of care standpoint as well as from an economic standpoint.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF SAM P. GIORDANO
EXECUTIVE DIRECTOR
AMERICAN ASSOCIATION FOR RESPIRATORY CARE**

The American Association for Respiratory Care (AARC), a 37,000 member professional association, welcomes the opportunity to submit testimony for the hearing on Long-Term Care of the House Ways and Means Sub-Committee on Health. Respiratory care is an allied health profession whose members care for individuals suffering from diseases and abnormalities of the cardiopulmonary system. These patients range from the premature infant whose lungs are underdeveloped to the elderly patient whose lungs are diseased. Individuals who suffer from such diseases as emphysema, bronchitis, and lung cancer, children who have asthma or cystic fibrosis, and people of all ages who require the use of a ventilator to breathe are all often cared for by the respiratory care professional. Respiratory care practitioners are the only allied health professionals educated, trained, and tested in the treatment and diagnosis of lung problems.

The AARC advocates reform which incorporates the principle of universal, non-discriminatory access to a continuum of comprehensive benefits ranging from preventive to continuing care services. Assured appropriateness and quality of care, improved system efficiency, and equitable cost containment should also be central goals of health reform. While there are many excellent components of the Clinton Administration plan, the area of greatest concern to the respiratory community is the utilization of Medicare coverage as a basis for the benefits package.

The AARC supports the Administration's efforts to address the needs of those Americans who are in need of long-term care (LTC) services. There is a growing recognition, supported by extensive cost information and data, that many individuals' health needs can be provided in care sites other than the hospital. For example, over the last few years there has been phenomenal growth in the number of sub-acute care facilities. This type of facility provides the level of care and services that are more intense than the nursing home, yet less complex than an acute care hospital. Ventilator-dependent patients, who require a medically-complex mechanical ventilator to help them breathe, increasingly are being transferred into sub-acute care facilities. These sites can provide an intensive rehabilitative climate, which, for some individuals, can mean weaning from their dependency on a ventilator. For others less fortunate, it means their lives can be made as comfortable as possible in a supportive health environment. While the numbers of ventilator patients in LTC facilities or at home are growing, you will find that few are Medicare patients. Health insurance for these individuals is most often provided by private insurance or, in some cases, by specialized state Medicaid benefits. Private insurance companies recognize the benefits of caring for these ventilator patients in the less costly and more appropriate care setting, yet Medicare does not. That is why Medicare non-hospitalized LTC patients are few and far between.

The Administration publicly supports and endorses the goal of promoting managed care and site-neutral benefits. In fact, the Administration plan specifically calls for the inclusion of a standard health maintenance organization (HMO) type of accountable health plan to be made available as a consumer option. A guiding tenet of HMO-structured care has been to provide the most appropriate level of care and services in the most appropriate care site. That is not always the acute care hospital. The Administration, though, is at odds with its own policy when it comes to respiratory care services. Without altering the way Medicare covers respiratory therapy or without an explicit clarification in the benefits package which would permit respiratory care services to be provided in the most appropriate site, LTC respiratory patients will be unable to benefit from the goals of Mr. Clinton's health reform initiative. They will remain tied to the acute care hospital, whether or not their medical condition warrants this level of care. The following information illustrates the current problems facing respiratory patients on Medicare. If changes are not made, similar problems will be faced by all respiratory-disabled patients regardless of age.

The following are examples of successful medical outcomes aided by LTC respiratory interventions. Neither of the two individuals are Medicare beneficiaries. Jared Landry, age 10, from Thompson, Connecticut, was born with muscular dystrophy complicated by underdeveloped lungs. He required hospital ventilatory support 24 hours a day for the first three years of his life. Through intensive respiratory care, Jared's medical condition is improved so that he now requires ventilatory support only at night while sleeping. Jared has been home and with his family since 1986. He is fully integrated into the fifth grade in the public school system. Another example is Mr. Billy Sutton, 57 years old from Jackson, Georgia. His lung disease deteriorated to the point where he required a ventilator to live. Instead of remaining hospital-bound, Mr. Sutton, with the help of his caregiver team, worked toward the goal of returning to his home, which is where he is today. He regularly participates in church and civic activities. These two stories are typical of the thousands of Americans who are respiratory-disabled and in need of long-term care services. By adopting Medicare respiratory policy unchanged, these individuals will no longer be able to receive their cost-effective, life-enhancing care outside of the hospital. While these stories are anecdotal, the data and information on both the barriers to, and the cost-effectiveness of, long-term, non-hospital respiratory care services are extensive.

A recent Gallup survey calculated the cost of providing hospital care to chronic ventilator patients. The survey estimates that on any given day, there is a census of over 11,500 chronic ventilator patients in U.S. hospitals. At a cost of about \$789 per patient per day, this totals over \$9 million a day for care of chronic ventilator patients. Once a patient is pronounced medically stable and able to be discharged, it takes an average of 35 days to place them in an alternate care

site such as the home or skilled nursing facility. That translates to an excess of \$27,000 per patient in unnecessary hospital costs.

An additional barrier to appropriate respiratory long-term care service is found in the antiquated Medicare restriction that permits only those respiratory care practitioners who are employed by a transferring hospital to provide covered respiratory therapy services to Medicare skilled nursing facility patients. This provision prohibits nursing homes from negotiating with other health care staffing entities to provide qualified therapists. This lack of access to other qualified RCPs hampers the ability of the nursing home from contracting for the most affordable and cost-effective therapy services.

Every study that looks at the cost effectiveness and appropriateness of respiratory care services outside of the hospital has indicated substantial cost savings. For example, a 1991 Lewin/ICF analysis estimated that treating cardiopulmonary disease patients (COPD) at home rather than the hospital would save the health care system \$48 million per year.

In the early 1980s, the Department of Health, Education and Welfare (HEW) sponsored a study that tracked 775 COPD patients, who received home respiratory services from a qualified respiratory therapist. The results of the study showed that hospital re-admissions for these patients were reduced from 1.28 per year to .55 per year. Furthermore, for the patients who were re-admitted to the hospital, the length of stay was decreased from 18.2 days to 5.7 days. The savings estimated for these 775 patients totaled \$1,097,250 (1980 dollars).

A 1982 conference on home care alternatives, headed by former Surgeon General C. Everett Koop, resulted in the initiation of three pilot home care studies. One pilot program in Maryland provided home care to respirator-dependent children and compared hospital costs and home care costs. The savings provided by home respiratory care were more than \$15,000 per patient per month. Over the 34-month period of the pilot program, \$3.1 million in savings were realized due to the availability of home care for these children.

A consensus conference on respiratory home oxygen care, cosponsored by the Health Care Financing Administration (HCFA) and the Food and Drug Administration (FDA), and attended by consumers and providers, recommended that, when necessary, home-bound respiratory patients should receive their care from respiratory professionals.

The AARC recognizes that there is a problem with waste and overutilization of services outside of the hospital. Yet, the health reform proposal is basing cost control on limitations of benefits, rather than limitations on utilization of health care resources. Utilization control is an area where respiratory care practitioners excel. In the hospital, it is accepted practice for the respiratory care practitioner to evaluate and assess the patient's response to therapy. This leads to timely modification of the course of treatment for a patient, which is beneficial to the health of the patient, and saves money through the wise use of health care resources. This role of assessment and utilization monitor is a role the respiratory care practitioner should be playing in the alternate care site as well. Our profession has well-researched and accepted clinical practice guidelines that spell out appropriate levels of respiratory care. In the hospital, the use of therapist-driven protocols that allow the respiratory care professional latitude in monitoring patient response to therapy has been shown to be cost effective.

These kinds of utilization controls, coupled with the fact that every study ever done on home respiratory care services documents cost savings and enhanced quality of life for patients, leads us to strongly urge the inclusion of LTC respiratory care services in all appropriate non-hospital settings.

Please do not perpetuate the medical coverage of the 1960s and limit Americans in need of long-term respiratory care to the most expensive care sites, such as the hospital, in lieu of other cost-effective alternatives such as the home, sub-acute care, or nursing home care.

Chairman STARK. Let me just ask each of you—you are all experienced with Medicaid and how it deals with services that you are concerned about. Given the choice as you would under the President's sort of block grant program or having the Federal Government establish minimum standards and procedures, would you rather see the primary role in methods and levels of payment decided by the States or the Federal Government?

Ms. Raphael.

Ms. RAPHAEL. I would rather see it decided by the States. I believe that they are closer to the population's needs and they can better tailor the programs. I don't think we can have one package of benefits that is right for every State and locality.

On the other hand, I do believe it is important to have some minimum benefits that are set at the Federal level and some standards setting and monitoring at the Federal level.

Chairman STARK. You can't have it both ways.

Ms. RAPHAEL. Then if I had to choose, I would say I would prefer to have the States do it.

Chairman STARK. Mr. Halamandaris.

Mr. HALAMANDARIS. Well, Mr. Chairman, as you remember, I did most of the investigations of fraud and abuse in government programs for Medicare and Medicaid, and it depends on your point of view from the point of view of government management a Federal system works better.

The Medicare program is not rife with fraud to the same extent that the Medicaid program is. From the point of view of fiscal integrity, that works better. From the point of view of the consumer, from the point of view of the client, a more flexible system tailored at the States and administered at the local level works better, so there are two sides of a coin.

Chairman STARK. You are suggesting that access is better in the Medicaid program than it is in the Medicare program?

Mr. HALAMANDARIS. Well, no. Access is limited by statute, so—

Chairman STARK. No, no. Is the access not limited by dollars in most States?

Mr. HALAMANDARIS. Well, I accept the point.

Chairman STARK. Paying 60 percent of what Medicare pays for a procedure limits access?

Mr. HALAMANDARIS. Well, I don't quarrel with you when you say that the Medicare program is better from the point of view of accountability and better in terms of what it pays. I agree that there needs to be a very strong Federal hand in terms of prescribing the program. We can't expect the Federal tax payer to foot the bill and have no responsibility for the management of the plan.

Chairman STARK. You are saying it better. Let's work on that. You can get that line down over time.

Mr. Pyles.

Mr. PYLES. Well, I represent quite a number of associations here today, and not all of them have spoken on this, but they have touched on it briefly.

The discussions we have had so far lead me to believe they would probably support a strong Federal role, and it seems to me one of the things that needs to—we need to make sure of in the health care reform process is that the dollars get down to the people who

need them, that the dollars get to the patients, that we minimize where possible duplicate bureaucracies that the States would have to set up.

I am not sure why it makes a lot of sense to Balkanize the health delivery system, whether it be acute care or long-term care by having each State have a different set of benefits. I think then you might well have citizens voting with their feet running from State-to-State, and States trying to craft benefit packages that run off the undesirables and attract the more desirable folks. We have seen that in the welfare programs.

So I would think the approach should be, where possible, to have national standards and national procedures to make the system as efficient as possible and make sure as much money gets into the service component and as little as possible into the administrative side of that.

Chairman STARK. Mr. Giordano.

Mr. GIORDANO. I believe it should be at the Federal level for the sake of consistency and efficiency. We had an experience with the Respiratory Health Act of 1985 where States were given an option to cover the professional component related to ventilator support, and only 10 States decided to exercise that option for various reasons. The fact is that 50 States come up against 50 different priorities and internal circumstances.

A uniform and consistent benefits package is best administered at the Federal level.

Chairman STARK. I guess generally we are reimbursing all of you now on some kind of a cost basis system. Would you prefer to stay with that or would you prefer to switch to a prospective payment system for your services?

Ms. Raphael.

Ms. RAPHAEL. I would prefer to move toward a prospective payment system. I think that would—

Chairman STARK. Mr. Halamandaris.

Mr. HALAMANDARIS. I think we need to stay with a cost-based system.

Chairman STARK. Mr. Pyles.

Mr. PYLES. The view of most of our members is that a prospective payment system will reward efficiency and innovation, so we would prefer that, I believe.

Chairman STARK. Mr. Giordano.

Mr. GIORDANO. Prospective payment system provided that clinical practice guidelines are in place to ensure that no underutilization or undertreatment occurs.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. If I could follow that question.

Mr. Halamandaris, you have been involved in the problems of the aging for a long time, going back to Frank Moss' committee and all the rest. When I was in the State legislature, I knew who you were.

When you say you think we ought to stay at a cost basis and each of the providers next to you says they ought to go to prospective, tell me what it is in your experience that makes you say that.

Mr. HALAMANDARIS. Well, as you point out, I go way back, and I have investigated a lot of systems that used prospective payment

systems to pay for nursing home care, and what happened inevitably was very wretched quality of care, a flat rate system which did not reward quality in any way, did not take in consideration increasing costs, and therefore the temptation was for providers to provide as little as possible and to retain as much as possible as profit.

The Congress was the one really that came up with the innovation of a system that recognized costs as a fair way of understanding the costs inevitably will increase, and if you do not recognize those costs, what happens is the quality tends to diminish in a hurry, and that is what I am concerned about most is the quality of services that are delivered.

I cannot come up with a system nor has anybody in my view come up with a system of prospective payment to home care that is fair and is reasonable, insures government the accountability it needs and also guarantees that the level of quality will be maintained. I think if we go to a prospective payment system, you will see the quality of care diminish.

Mr. McDERMOTT. Are you willing to extrapolate from your experience to the acute care side that the capitation of a health maintenance organization has the real potential for the same problem?

Mr. HALAMANDARIS. Yes, sir, it does. There are, I think, a fair number of studies and investigations over the years that bear that out. If you look at the record of the Senate Permanent Investigations Committee in 1974 through 1978, they did rather extensive studies of health maintenance organizations and found this to be a significant problem, so there are risks involved when you go to capitation.

I am not saying that is a reason not to do it, but there certainly are risks.

Mr. McDERMOTT. As each of you has looked at this issue—and again I would start with you Val—the question of how is this all going to integrate with each piece because we have not put in a seamless piece of health care from acute care through home care to chronic care in an institution.

As you read the bill and as you look at the proposal that the President has made, what are the problems that you see in how or where people are going to fall through the cracks?

Mr. HALAMANDARIS. Well, I think there will be a fair amount of confusion with respect to long-term care. Specifically, the chairman pointed it out, and I think you did as well, is it a Medicare program or not. The elderly already are confused, is it going to be part of Medicare or out or different? I think that is the key element.

As I have traveled the country, people really need something to happen in the area of long-term care. That is where the confusion is going to be, and we need to address it.

Ms. RAPHAEL. I would kind of second what Val said. As a provider in the new world of long-term care, we are going to have some people who are Medicare beneficiaries who get a home health benefit under Medicare. We are going to have some people who remain in a State-devised Medicaid system who are low income and will get a benefit under that Medicaid program.

We will have some people who are going to hopefully get the minimum benefit provided in the new reform plan, and then we are

going to have some people who are going to get this new State entitlement or block grant program, and how all of those four pieces will fit together I think is a real issue.

In addition to which I think even if you use the functional disability levels of three ADLs that is currently stipulated, it is entirely possible that there will be more people in any State and hopefully all States would choose the option to do this, but there will probably be more people who fit that kind of level than dollars to provide the care.

I foresee that given what I see as the need currently, and I think there will be issues as to how to best target who should receive that care and how to deal with the residual group whom you can't possibly afford to provide care to.

Mr. PYLES. It seems to me that if you look at the acute care portion of the bill and the long-term care portion, they are schizophrenic. They take completely different approaches. They obviously were written by two different groups of folks.

At the very least, as I mentioned in my testimony, it seems to us that the approach should be consistent in both pieces, and certainly we endorse and applaud the provider access and consumer choice that is maintained in the long-term care piece, but we think that should also be in the acute care piece as well.

Again, even within the acute care piece there seems to be a certain schizophrenia on the one hand of having a strong role for the Federal Government with the National Health Board, but then on the other hand allowing the States to go off and do a lot of their own things.

It seems to us that the role of the Federal Government in this process should be to establish a unified system, one with standards that are the same or generally the same throughout the country and a process that is generally the same throughout the country, preserve access to market access by providers, choice by consumers then allows providers to compete within that program.

I think under an approach like that, a truly Federal approach, I think you will then see high-quality cost-effective services being provided and innovation be preserved.

Mr. GIORDANO. I think that the system should recognize episodic care. When people are ill, that is the beginning of an episode. That episode could begin with a physician office visit. It could entail an admission to an acute care facility, and could also entail discharge to a community-based services organization.

The fact is the current language does not recognize one episode. By virtue of the system being disjointed, then what we invite is turfing patients to the most costly patients to the other person. I think that we have to integrate, recognize seamless care or the continuum of care. If we are to faithfully follow through the episode of care for the beneficiaries in such a way so they are not under treated.

With regard to the cost-plus reimbursement as opposed to prospective pay, I think Mr. Halamandaris hit the nail on the head. There is a risk of replacing a system which some would characterize as offering an incentive to overtreat patients with a system that would offer an incentive to undertreat. That is why we have to put

a safety net in there of practice guidelines that assure that the patients get what they want.

By the same token, we need to——

Mr. MCDERMOTT. What they want or what they need?

Mr. GIORDANO. What they need; beg your pardon.

By the same token, we need to integrate community-based services with acute care organizations so that we can recognize that one episode and perhaps then be in a position to monitor the care within that episode.

There is no question that because of prospective pay being introduced in the acute care facilities, that many chronically ill respiratory patients are discharged from the hospital much quicker, much sicker, and they tend to consume more on the part B side now of the equation than they did before.

Mr. MCDERMOTT. Let me just take an example and let you all sort of react to it. A 57-year-old person with emphysema who gets an acute respiratory difficulty winds up in the hospital, and then is after a few days put into the community.

What is your expectation of how it will work for that person under the new system and the same for somebody 67-years-old who gets an acute episode and then is put back in the community? How do you see it working for that patient under those two circumstances, given 10 years difference in age and therefore one being in Medicare and the other not, one being in the national system?

Mr. PYLES. Well, one difference I see, quite quickly, is that if you have regional health plans that generally tie up most of the patients in an area, this patient will go to the one health plan, probably come into the hospital rather than perhaps being evaluated for noninstitutional care first, will go not to the provider of his choice but to the provider that is affiliated by some sort of corporate affiliation with the integrated delivery system that controls the plan.

The 67-year-old may or may not go into a system like that, probably not, but probably will again go into a hospital first, but there is much more chance I think they would be evaluated for home care first under Medicare, and I think probably as Medicare operates right now, would probably have more choice as to whether he goes to the plan or the hospital's outpatient or home care company or to the one of his choice.

I think there is more choice now under the Medicare program.

Ms. RAPHAEL. I would expect that the 57-year-old person with emphysema would come in under sort of the new Federal program and therefore would get home care attached to the health plan, and that would also depend on the choice that person made, whether or not to go into a health maintenance organization point-of-service plan, fee-for-service plan, but that benefit would have to be in lieu of hospitalization because currently the benefit says that home care can be provided as a substitute for institutionalization, which means a stay in a hospital, a rehabilitation center or a nursing home, so that person would be handled under the current proposed benefits.

The 67-year-old identical person, except for 10 years more of age would be, I think, handled under the Medicare system, and would likely fall under how that benefit is defined as an intermittent ben-

efit for home bound people for certain skilled care for a certain amount of time, so I think that they would actually have a very different experience under the current proposal.

Mr. McDERMOTT. Better or worse? If you had to choose.

Ms. RAPHAEL. My sense of it is that it is hard for me to gauge because the home care component of the new proposal hasn't really been fleshed out, so it is hard for me to know. I think it could very well—I think the Medicare system currently works quite well. I think most people are very satisfied with the care with one exception.

It does not provide for custodial care and personal assistance that is sort of the key missing element, but I think in terms of quality of care, responsiveness of care, competency of providers, I think that system right now is a strong system.

Mr. McDERMOTT. And your expectation is that the 57-year-old would be covered under the acute plan as an alternative to hospitalization whereas rather than under the State plan that the President is setting up for community care, that is another benefit?

Ms. RAPHAEL. Right. That would be my sense of it unless that person is sort of permanently severely disabled by emphysema, and then it is conceivable if that person is really severely and sort of disabled on a long term basis that that person could convert to this long-term care State option plan.

Mr. HALAMANDARIS. You put your finger on it, Mr. McDermott, as you always do. The 67-year-old man is my father. My father had black lung disease because he was a coal miner. He had a heart arrhythmia. He had diabetes. The most common profile of the patient receiving home care are those three together.

His life was always in a delicate balance. He continued to work until the day he died, but as you know, they had to monitor his blood sugar very carefully, had to monitor also the thickness of his blood, give him blood thinners, so he was always at risk of edema, risk of having a stroke, a risk of going into shock because his blood sugar was too high, and inevitably he went into the hospital a couple of times for congestive heart failure.

What we were able to find out through the intervention of home care services and nurses that came sporadically is that we were able to keep father at home and to prevent several of those episodes which surely would have placed him in the hospital. I wonder now under the Medicare program, if you consider my father and having exhausted those benefits, how he would interface with the new long-term care plan which is a State plan and not a Federal plan, a grant program and not an entitlement program.

So as I said, you have put your finger on a significant problem in transition there. The 57-year-old individual with the problem is the one that Carol alluded to, the quirk that is in the statute which limits its payment toward individuals in order—as an alternative to hospitalization, it may be that in the first instance the 57-year-old individual stumbled into a doctor's office, was seen by a home care nurse, can he be treated there by physician's order.

Does it require him to be funneled through the hospital to receive that home care service that would leave him at home? I would assume that if the Congress can fix that point, that that same individual could move into a fairly seamless long-term care

program, but again it is a different program. It is a State program and a grant program so the transition between those two programs is still different on both sides, and your analogy, whether you are talking about the 57-year-old or the 69-year-old, those transitions are going to be very difficult.

Mr. GIORDANO. I will make it short because the respiratory care benefit doesn't exist in Medicare so there will be no difference in the 57-year-old or 67-year-old. If they were to require the services of a qualified respiratory care practitioner, they will have to check into a hospital to receive those service. Patients would then be discharged. If they need oxygen at home, they will get it. If they need a ventilator at home, they will get it. But if they needed a respiratory care practitioner, they would not get it.

Mr. MCDERMOTT. Let me ask you a question, and I appreciate the chairman's indulgence. Let me ask you, there appears to me as I read the President's plan to be a point at which when the State gets its plan up and running they can make a petition to the Federal Government to bring in the Medicare patient. I am not quite sure whether or not the patient has any choice in that or not. But if the patient had a choice, which would we recommend? Would you advise them to stay in the Medicare plan or would you advise them to go into the program of the national health plan?

Mr. HALAMANDARIS. Well, my response would be to stay in the Medicare program because of what you said a while ago. The Medicare program is tried and true and tested and has been around for a long time. And there will be certain expansions that the Congress put into place. That is a certainty. Whereas the new benefits to be structured are still as yet unclear. And until we have a chance to evaluate them, I would stay in the secure course.

Ms. RAPHAEL. I agree with Val. I think there are benefits and liabilities of each choice, but I think the more secure choice is to stay in the Medicare plan. At least then you know you are entitled to some defined benefit for some period of time. If you go into the other plan, it is possible the dollars could run out at some point in the year. Your service may have to be diminished. There may be some kind of targeting that will let you out. Also, it is not entirely clear what the benefits will be in that plan. Right now the core is assessment, plan of care development, and personal care. At some point, you may need some skilled service, whether it is rehabilitation or nursing service. And it is not clear that those would be available to you.

Mr. PYLES. I would certainly suggest that they stay in the Medicare plan because of choice, which is more readily available there, and because the coverage is more available for home care there with the limitation being only medical necessity. Whereas, under the President's plan it has to be an alternative to inpatient case. And in my mind that is somewhat more restrictive plus there is the uncertainty of how these plans will shake out. Some plans may not be successful. Some, like the Blue Cross of the National Capital Area, may be threatened with bankruptcy. So I think in the near term the Medicare plan would be a safer bet.

Mr. GIORDANO. I agree. They should stay in the Medicare plan. Once the rubber hits the road, there is going to be new ideas and new concepts. Nothing ever works as planned. And I think it is un-

fair to put the elderly through that sort of stress and uncertainty and anxiety when it is not necessary. I think it can be tested with the rest of the population and once it is refined to the point there could be a transition, then a transition could be considered. At the same time, it will give an opportunity for the damages in benefits to become clarified as well.

Mr. McDERMOTT. Thank you very much. Thank you, Mr. Chairman.

Chairman STARK. I thank the panel very much for their participation.

Chairman STARK. Our fourth and final panel is comprised of representatives from the nursing home industry: Paul Willging, executive vice president of the American Health Care Association; Michael Rodgers is the senior vice president of the American Association of Homes for the Aging; and Mr. Richard Thorpe, executive vice president of the American College of Health Care Administrators.

Paul, do you want to lead off?

**STATEMENT OF PAUL WILLGING, PH.D., EXECUTIVE VICE
PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION**

Mr. WILLGING. Thank you. I will summarize my submitted testimony.

It is indeed a pleasure to be with you. Or pretty much a pleasure. Twelve hours ago I was in your fair State, at San Diego. I now acutely understand what the term "red eye" means. But I don't think I would have missed this major event; the first discussion of the long-term care components of the President's proposal for health care reform.

As have all the other people who have testified before you today, we certainly do commend the President and the First Lady for having brought the issues to the table—what will start one of the first major discussions of overarching health care reform since the mid-1960s.

We are equally interested and indeed pleased to see that in his proposal the President has provided a focus on long-term care. There has never been a question, of course in our minds, that any meaningful discussion of health care reform needs to deal with the issue of long-term care, and many of us in this country would look to that as perhaps the primary issue of concern as far as their lives are concerned.

We are also equally pleased with the implicit emphasis in the President's proposal on the concept of the public-private partnership. There is no question that the potential demand for long-term care services—the incredible need for long-term care services would not lend itself to a system in which the government would be the sole payer. Rather, the President recognizes in his emphasis on long-term care insurance that indeed the government's primary role is to handle service payments for those who cannot plan themselves and to utilize such concept as long-term care insurance for much of the private sector.

We are equally impressed with the President's emphasis on what we referred to as subacute care. The recognition that there are certain services heretofore provided exclusively or certainly predomi-

nantly in the acute care setting that can be handled equally in alternative setting, be it the nursing home or the home, or the hospice setting.

This is a burgeoning area in the long-term care arena. Subacute is growing dramatically. And we were impressed with the First Lady's poignant discussion of her own father's needs and the extent to which the current financing system forced those needs to be handled in an inappropriate setting, the hospital. We look forward to working with you.

There are areas where we wish to discuss with you over the course of the next months and year including some concerns that we think have to be addressed starting with the employer mandate. Nursing homes, Mr. Chairman, are small businesses. We average about 100 employees. We average about \$3 million in revenues, and we don't insure those employees to the extent we should. We would in fact be advantaged by having a system wherein that insurance would be made available.

On the other hand, since our primary payer is the Medicaid program, we need to be assured that Medicaid would recognize these costs that we would be incurring. And that leads to the concept of State flexibility. While a laudable concept, much of our problem in years past has been the degree to which States found it difficult to fulfill their financial responsibilities with respect to long-term care. We made great progress over the last 7 years as a result of the nursing home reform provision in OBRA. Those have been met with some financial difficulty by the States. We don't wish to back-track on those kinds of quality assurance mechanisms and therefore I think the concept of flexibility has got to be tempered with the concept of State responsibility.

We look forward to working with you over the course of the next months and year as we focus on the long-term nature of the overarching issue of health care reform. Thank you very much.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY

Before The

HOUSE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

November 2, 1993

by

PAUL WILLGING, Ph.D

Executive Vice President

American Health Care Association

Mr. Chairman, members of the Subcommittee, I'm Dr. Paul Willging, Executive Vice President of the American Health Care Association (AHCA). On behalf of our more than 11,000 nursing facility members across America, thank you for providing me the opportunity today to address this panel. I commend you, Mr. Chairman, for holding a hearing on what we obviously feel, as do millions of Americans, is one of the most critical issues in the health care reform debate -- the issue of long term care.

We applaud this Subcommittee, President Clinton and the First Lady for taking courageous action to address a failing health care system. With thousands of employees and more than one million residents currently in our facilities, obviously we are most concerned with how far-reaching health care reforms will affect long term care.

Our first reaction, however, is one of hope and support for a much-needed and critical effort; and of eagerness to work with this Subcommittee and with the Administration toward meeting the long term care needs of all Americans.

We are excited that President Clinton has outlined a bold plan to ensure that all Americans will have health insurance and to finally gain control of spiralling health care costs, and strongly support many aspects of the Clinton reform plan.

Long Term Care Insurance Reform

In particular, we applaud the provisions to expand and improve the availability of long term care insurance. Many of the provisions of the Clinton plan also are included in AHCA's Quality Care For Life proposal, including the establishment of minimum federal long term care insurance standards. We support and applaud provisions to:

- * establish standard definitions, terms; and periods of benefit duration;
- * clarify that the cost of long term care insurance and policy payments made to beneficiaries would be excluded from income for federal tax purposes;
- * include expenses for insurance policies as deductions for medical expenses; and, perhaps most importantly,
- * provide that employer-paid premiums would be treated as tax deductible expenses for employers.

While we support these provisions, it is critical that they be implemented in such a way that regulations and provisions not increase costs and make long term care insurance unaffordable.

Innovative Programs

AHCA applauds innovative programs to provide grants for educating consumers about the need for long term care insurance and for conducting a demonstration program for the integration of acute care and long term care -- and Mr. Chairman, I'll be more specific about this concept in a minute when I discuss our proposal for a new subacute level of care -- a proposal to potentially save the federal government billions of dollars.

Subacute Care and Enhanced Competition

In particular, we agree with the First Lady's support for removing barriers to competition among health care providers and for establishing new public/private partnerships for the delivery of long term care. In her testimony on September 29th before the Senate Labor and Human Resources Committee, the First Lady stated, "we want to provide reimbursement for subacute care at nursing facilities rather than in a more expensive hospital setting."

It is important to note that internal estimates by AHCA illustrate that allowing our skilled nursing facilities (SNFs) to compete for patients who are not in need of intensive acute hospital care, but who are still medically fragile, could save untold billions per year in reduced federal costs. A new reimbursed subacute level of care is defined as a comprehensive inpatient program designed for the individual who:

- * has had an acute event as a result of an illness, injury, or exacerbation of a disease process;
- * has a determined course of treatment; and,
- * does not require intensive diagnostic and/or invasive procedures.

In these cases, the severity of the individual's condition requires an outcome-focused interdisciplinary approach utilizing a professional team to deliver complex clinical interventions (medical and/or rehabilitation). These highly specialized programs promote quality care through efficient and effective utilization of health care resources.

In a nutshell, Mr. Chairman, if artificial barriers were removed and competition enhanced, new and existing subacute skilled nursing facilities will provide quality health care for patients currently parked in acute care hospitals -- but at one-third to one-half the cost! The program barriers that must be removed include:

- * eliminating the 3-day prior hospitalization requirement for subacute care patients eligible for Medicare skilled nursing facility admission;
- * allowing respiratory therapists in subacute nursing facilities to be reimbursed directly for providing care;
- * equal reimbursement for physician visits, whether to skilled nursing facilities or hospitals;
- * lifting of routine cost limits (RCLs) for subacute nursing facilities;

Mr. Chairman, let me emphasize that we support a continuum of long term care enhanced by competition and a level playing field. These barriers, prohibiting skilled nursing facilities from easily and readily providing quality long term care at greatly reduced cost to the federal government, make little or no sense. They must be eliminated. The First Lady is right regarding the need to remove these barriers and we hope to work with you on this key issue.

Extended Care Options

Overall, the long-term care provisions of the Clinton plan provide opportunities for improving efficiency and quality care for millions of Americans. The new-100 day extended care benefit clearly recognizes, as we do, the need for a continuum of care, but a prior acute hospitalization requirement is imposed for the skilled nursing facility (SNF) benefit. This is a barrier that increases costs and restricts SNF and HMO flexibility.

It is important that we support alternatives to long term institutional care where viable, but we are concerned about the costs of a new "capped entitlement" program offering services to a portion of the population that is not currently being served. In most cases, patients currently served by our members cannot be served in any other setting because of the acuity of their medical problems.

Any new program designed to cover long term care should seek to strengthen the entire continuum -- and not enhance one component at the expense of another. Whether in a hospital, a subacute skilled nursing facility, a nursing facility, or in community or home-based care, a patient should be provided care on a level playing field that determines the most cost effective and safe setting of care.

State Options

In previous hearings, Mr. Chairman, you have expressed your concern over state flexibility. We share your concern in several ways. We are concerned that state flexibility not increase overall Medicaid costs and provider paperwork. Most importantly, the proposal for state flexibility to cap community and long term nursing facility care expenditures is frightening.

Despite recent Administration assurances that long term care in nursing facilities would not be capped, conflicting testimony by other Administration officials before this Subcommittee, causes us great concern. The question has not been adequately answered yet as to who will pay for Medicaid recipient care when a State reaches its funding limit under a new combined capped program.

It is also vital that state flexibility not threaten the integrity of the "Boren Amendment", which requires States to pay nursing facilities the cost of efficiently provided long term care.

Employer Mandates

AHCA members, primarily proprietary small businesses, provide jobs, tax revenue and stability to communities across the United States. Many of our personnel are low-wage employees who do not have complete health care family coverage. The imposition of the employer mandates will, despite all good intentions, have a dramatic effect on some of our members. It is critical that the Congress and the Administration work together to ensure the least possible negative economic impact from the imposition of new mandates for health coverage on small businesses, such as nursing facilities.

The recognition that we provide a critical link in the health care delivery system in America is important, and we must not impose economic hardships or burdens that result in decreasing the number of nursing facility beds for an aging and longer-living population. The elimination in 1993 of Medicare Return on Equity payments to skilled nursing facilities already has dampened the outlook significantly for nursing facility expansion in the near term.

There are other outstanding issues of concern to AHCA, but in the broad context of health care reform, the proposal before you is a good one that will lead to the kind of system all Americans know we are capable of designing. In particular, Chairman Stark, I want to applaud you for your dedication to overseeing each detail of this proposal and for proposing far-reaching and bold legislation of your own. We recognize your support of long term care reforms that have increased the quality of care for Americans in our facilities.

AHCA is particularly pleased that Congress continues to recognize the need to develop a Prospective Payment System (PPS) for SNFs that incorporates resident acuity, efficiency incentives and fair value rental for property and administrative costs. In particular, Mr. Chairman, your effort to establish this new system is greatly appreciated. We are concerned, however, that the proposed freeze on routine cost limits ignores the need to move toward PPS reimbursement for skilled nursing facilities.

We eagerly await the Congressionally mandated report of Secretary Shalala on such a system and stand ready to work with HCFA and the Prospective Payment Commission (ProPAC) in any way possible. The ability of HCFA and ProPAC to design such a system is critical to increasing efficiency and quality in our long term care delivery system.

In conclusion, our priorities are to support sound legislation to:

- * remove barriers to long term care and establish a more cost-effective program for subacute care in skilled nursing facilities under Medicare;
- * level the playing field in providing quality long term care by providing equal treatment and reimbursement for equal services, without regard to setting;
- * establish federal standards and consumer protections and clarify federal tax rules to stimulate public/private partnerships in providing long term care;
- * ensure that any artificial caps on funding will not jeopardize the ability of nursing facility providers to meet federal requirements and provide quality care;

- * ensure that a federal mandate that employers provide health coverage to employees not threaten the ability of nursing facilities to retain the staff they need to deliver quality services;
- * eliminate regulatory barriers, paperwork burdens, duplicative surveys, and inspections that hinder, rather than help, enhance the ability of providers to offer quality and cost effective long term care.

Mr. Chairman, our members are in business to provide the finest long term care available in the world. Our nursing facilities are regulated more heavily than any other business in America. We are eager to reduce costs to the federal government for long term care and support efforts to stimulate private sector involvement in paying for long term care rather than increasing costs to taxpayers and the States.

We ask that you improve the legislation before the Congress. Allow us to compete in a new continuum of health care. Remove those barriers to efficiency and level the playing field. Provide incentives for businesses to provide quality and affordable long term care insurance for their employers, and all Americans, whether infants, teenagers, or those currently in institutional care, will benefit and prosper.

Thank you, Mr. Chairman, for allowing us to make our case for a subacute and long term care delivery system that works for all Americans.

Chairman STARK. Mr. Rodgers.

STATEMENT OF MICHAEL F. RODGERS, SENIOR VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. RODGERS. Thank you, Mr. Chairman. We appreciate the opportunity to testify today on several aspects of the administration's plans, and we would like to commend you and members of this subcommittee for the extraordinarily exhaustive hearing schedule, both last week and in the weeks to come.

Our association has a unique vantage point. Our members encompass a number of levels of care. We are not just nursing homes or community or home care providers but include members that cover all service needs of the elderly. As such, our bias for a particular service perspective actually spans the continuum. With this bias in mind, we are happy to comment on aspects of the President's plan. We are still studying the finer details of the plan and will limit our comments to some of the broad-based aspects involved with the delivery of LTC services.

In general, we are encouraged by the overall direction of the President's plan, although we have some specific concerns. I would like to concentrate on three areas of concerns this afternoon.

First is the development of programs to cover catastrophic long-term care costs; second, the improvements in the plan on home and community-based service programs; and, third, the need to integrate some of the services of both acute care and long-term care.

The American Association of Homes for the Aging has a long-standing position of supporting a public-private partnership to finance long-term care service. Under our proposal, Federal insurance protection will be provided to cover catastrophic long-term care needs; a back-end coverage, if you will. While we are encouraged that the President's basic benefit package—

Chairman STARK. Go through that again slowly until we understand what you just said.

Mr. RODGERS. Under our proposal, the AAHA proposal, we are looking for Federal insurance to cover the catastrophic long-term care needs of older or disabled individuals. Generally speaking, this is a stop-loss provision where an individual would take personal responsibility for, say, the first 12 to 24 months of long-term care needs and then the Federal Government would come in with a social insurance program. Obviously, individuals with limited incomes would continue to rely on public benefit programs to finance such services.

Chairman STARK. And the private insurance companies would focus on that initial period of time?

Mr. RODGERS. That is correct.

While we are encouraged that the President's basic package includes expanded extended care services, we believe that Congress needs to find a way for all individuals to protect themselves against these kinds of catastrophic costs associated with long-term and institutional care, especially those problems that lead eventually to impoverishment.

There are a series of other components that we are supportive of in the President's plan, including incentives that promote the development of long-term care insurance as well as provisions that

increase the resource allocation of resource limits and liberalize the personal needs allowances.

Let me move on, Mr. Chairman, to the home and community-based services programs.

AAHA has long been a supporter of expansion of home and community-based services. The majority of our members have long recognized the importance of going beyond the brick and mortar of assisted housing, especially as it relates to assisted housing for the elderly. As we prepared for hearings with Mrs. Clinton in Florida, we surveyed some of our assisted housing providers, the residents in section 202 housing, and we asked them if they were without the section 8 subsidy what would they have to forego; what kind of lifestyle changes they would have to make? And almost to a person they said they would have to drop their medigap policies or cut back substantially on prescription medications. So we support this expansion of home and community-based service programs. We think it is an valuable alternative in the continuum, but there are some limitations.

We are specifically concerned about the fact that States may try to cut back on their commitments to institutional care, as well as the fact——

Chairman STARK. Or squander the money to political allies as they do in the District of Columbia; \$2,000 section 8 apartment; Watergate.

Mr. RODGERS. The other issue that needs to be noted regarding home and community-based services is that they should not be viewed as a cheaper alternative to other forms of institutional care. I think that the direction of HCFA has noticed this. And I think it is a misconception that is constantly thrown out. It may be a more humane option but not always a cheaper option. I don't think we can confuse the issue of marginal costs with average costs in this area.

Finally, just a quick point. We are pleased that the President's plan includes a demonstration to link acute and long-term care services, but we believe that Congress as it considers its legislation should consider more formal linkages. Mr. Chairman, we know that last week you expressed some concerns about the difference between the Medicare and the health alliance programs. We also feel that by separating long-term care from the acute care system we are treating this differently, and it will continue to be viewed, that is long-term care will continue to be viewed as kind of the stepchild of the health system.

We would encourage the committee to look at demonstrations like the social health maintenance organization and the On Lok replication projects as ways in which long-term care services can be included in this continuum.

Mr. Chairman, thank you very much for the opportunity to testify today. We look forward to working with this committee as it drafts legislation.

[The prepared statement follows:]

**TESTIMONY OF MICHAEL F. RODGERS
SENIOR VICE PRESIDENT
AMERICAN ASSOCIATION OF HOMES FOR THE AGING**

**A PARTNERSHIP IN CARING:
AAHA's LONG-TERM CARE REFORM PLAN**

INTRODUCTION

Mr. Chairman and distinguished members of the Committee on Ways and Means, the American Association of Homes for the Aging (AAHA) appreciates the opportunity to testify today on the critical issue of health care reform. We are pleased that this issue is a top priority on both the President's and Congress' domestic agendas and stand ready to lend our organization's assistance in helping craft a solution to insure adequate access to quality health and related services, financial protection for these services and mechanisms to control spiraling costs.

AAHA is a national organization representing almost 4,500 nonprofit providers of health care, housing and community-based services for the elderly. AAHA is committed to the reform of our nation's long-term care system as an integral part of health care reform. Only through such reform can we assure our nation's 32 million elderly citizens of access to needed long-term care services and adequate financing for such care. Representing providers who collectively offer the full range of aging-related services, the Association recognizes the value of a vast array of housing and health-related services to ensure that the chronically-impaired elderly receive appropriate and cost-effective care in the most appropriate setting which accommodates their individual needs and circumstances.

Mr. Chairman, we appreciate and applaud your efforts to ensure that long-term care remains an vital component of the health care reform movement that has swept this country in the past year. As you will know, dozens of bills have been introduced in the past several years to reform the health care financing and delivery system and to increase access to basic medical protection for the 37 million Americans who currently are uninsured and a roughly equivalent number of individuals who are underinsured.

Notwithstanding the critical condition of our overall health care system, however, the needs of our elderly citizens must not be overlooked. Two-thirds of our nation's poor elderly are not covered by Medicaid for acute care and emergency services. Roughly 32 million older Americans are without financial protection against the potentially catastrophic costs of long-term care services. With nursing home services approaching an average annual cost of \$36,000, not many elderly persons can afford to pay for this care out of pocket with median incomes of \$22,000 per year for households headed by a 65 year old person and roughly \$9,500 for those not living in families.

LONG-TERM CARE: THE PROBLEM

The problems of the long-term care population are not dissimilar to those of the general population. There are currently almost 32 million Americans over age 65 who are uninsured against long-term care risk. Medicare and private LTC insurance account for only three percent of total annual long-term care expenditures. Over 48 percent of these costs are paid directly out-of-pocket by the elderly and their family members. The rest are financed through public assistance under the federal/state Medicaid program. Medicaid benefits are available for the low-income and those who become impoverished as a result of uninsured long-term care expenses.

The difference between the population lacking health insurance coverage and those lacking long-term care protection is that the problems of the latter population represent only the tip of the iceberg. Those over 65 represent the fastest growing segment of the population; the 85 plus group will grow more rapidly than any other elderly cohort. By the middle of this century, the over 85 population will grow from 10 percent of the elderly to one quarter of this population. These demographics have frightening implications for the long-term care delivery and financing systems. Fully 50 percent of those 85 plus need assistance with activities of daily living; 61 percent need assistance with meals, shopping and chores. Yet less than three percent of the expenditures incurred for chronic care services are insured.

Long-Term Care Micro-Economics

According to the Congressional Budget Office, the per capita costs of long-term care could double between 1990 and 2010 based on demographic trends, health care inflation and service intensity. The average cost of nursing home care currently stands at \$36,000 annually. Depending on geographic location and other factors, these costs run as high as \$50,000 to \$100,000 annually. The costs for home-delivered chronic care services can also place a tremendous burden on the elderly and their families. While lower than nursing home costs in some cases, home care costs for an individual receiving three visits per week would range between \$10,000 and \$15,000, depending on the type of services and providers involved.

The financial impact of long-term care expenditures at the micro level can be devastating. The chance of entering a nursing home at age 65 is about 43 percent. The likelihood of being disabled in the community is even higher. Of those who do enter nursing homes, about 27 percent will stay for one year or more. About 21 percent will have lifetime stays of five years plus, representing truly catastrophic expenditures. About 56 percent of those who incur long-term care costs will spend up to \$50,000. Almost 70 percent of women — those at greatest risk — who have assets of \$10,000 to \$25,000 at age 65 will have out-of-pocket expenditures for long-term care which exceed their assets. Direct care costs are only part of the picture. More difficult to quantify are the costs to family members including financial, emotional and physical stress; costs to businesses in terms of sickness, lost time and diminished productivity; and the costs to the entire nation resulting from a major unfunded liability.

Long-Term Care Macro-Economics

The cost of Federal proposals to ameliorate the long-term care financing dilemma have ranged from \$25 billion to \$60 billion. Even the Pepper Commission approach which has garnered more political support than any other plan, and includes only limited coverage of nursing home care, is weighing in at about \$50 billion (these figures cover costs for chronically impaired of all ages). Given a federal debt approaching \$4 trillion, a projected budget deficit in 1993 in excess of \$300 billion and the President's strong commitment to deficit reduction, such program options do not seem economically feasible, at least in the foreseeable future.

The states are also staggering under the burden of escalating budget deficits. Twenty-nine states were forced to reduce their FY 1991 budgets to account for impending shortfalls; two thirds of states had to reduce their budgets in 1992. According to a 1992 report by the National Governors' Association, state year-end balances were the lowest in 15 years. Moreover, the growth of state spending in FY 1993 is projected at roughly one quarter the average growth during the 1980s. Medicaid, which accounts for close to 90 percent of public spending on long-term care, is a major culprit in the states' fiscal crisis.

Federal mandates have increased Medicaid spending 20 percent in just the last two years. Half of the new revenues in 1993 will be generated by mechanisms such as licensure fees, environmental fees and assessments on health care providers. Increasing pressures on state Medicaid budgets are exacerbated by the growth in long-term care expenditures. Roughly 27 percent of the nation's 28 million Medicaid recipients are aged and disabled with the remaining 73 percent composed of families. Yet 68 percent of total Medicaid dollars are spent on the former category, in large part, due to the growing costs of nursing home care.

Improving access to affordable LTC services will require a strong partnership between the public and private sectors. Both sectors should be encouraged to develop innovative financing and delivery models that accommodate the unique needs of special populations, promote quality assurance and provide services in the most cost-efficient manner. To be fiscally viable, such proposals must recognize the current budgetary constraints facing federal, state and local governments and promote an effective public/private partnership.

**AAHA LONG-TERM CARE REFORM PLAN:
A RESPONSE TO THE CLINTON ADMINISTRATION**

AAHA has a long-standing position of support for public/private partnerships in financing long-term care services. Furthermore, it is critical to clearly articulate the role of each sector to ensure a complimentary system of coverage. Given the fiscal crisis at the federal and state levels, and the tough competition for scarce public resources within and across interest groups, AAHA firmly believes that individuals who have the ability to self-finance long-term care risk should do so. Strong incentives should be provided to promote private financial protection through vehicles such as long-term care insurance. We applaud the Administration's proposal to include a series to tax credits and other incentives that encourage the development of LTC insurance.

Under AAHA's LTC Reform Plan, federal insurance protection would be provided to cover catastrophic nursing home care (i.e., stays in excess of 12-24 months). Individuals would self-finance the nursing home deductible period, supportive services and copayments. These services could be financed through private funding or private long-term care insurance.

While we recognize that fiscal realities may preclude a more extensive nursing home benefit under the President's plan, we encourage the Congress to explore ways that such services might eventually be covered. On a related point, we are pleased to see an expanded "extended care benefit" included in the basic service package. AAHA believes that skilled nursing and rehabilitative services are a cost effective alternative to more costly hospital services, and should be included in any legislation eventually developed by this subcommittee.

As an organization that represents a wide variety of providers in the continuum of care, AAHA supports the expansion of long-term care services to cover home and community-based programs. Such programs recognize that the vast amount of frail elderly prefer to be served in their own homes. AAHA believes that public funding for home and community-based care could be used to cover supportive services provided in the community-at-large or within residential environments such as senior living or assisted living facilities. The housing portion (i.e., brick and mortar) or residential care for the needy should continue to be financed through other programs such as HUD rental subsidies, Supplemental Security Income, etc.

AAHA strongly believes that both federal and state housing assistance has a direct bearing on health status and feeling of well-being among the elderly. For example, a recent survey by one of our members showed that residents receiving federal housing assistance were able to finance their own Medigap policies and prescription drugs. Without such rental assistance, many of these individuals would be forced into public assistance programs to finance needed health benefits.

Other examples of the benefits of assisted housing abound. With the supportive services available through the Federal Congregate Housing Services programs, older persons in 60 sites across the country are saving the federal government an average of \$5,000 annually by avoiding premature institutionalization.

While AAHA is highly supportive of expanding home and community-based care, as outlined in the President's plan, there are several caveats we would like to share with this subcommittee.

First, although we support expansion of this benefit and the accompanying need for state flexibility, we are concerned with the potential cost shift of funds away from long-term nursing home services into home care. We believe states may be tempted to seek less costly ways to fund their chronic care responsibility, and seek a temporary "fix" through expanded home care. Make no mistake; the level of frailty and infirmity in nursing facilities is increasing. We seriously doubt many of the existing residents in nursing facilities can be cared for in the community.

Secondly, there is this prevailing and insidious notion that home care is a far less costly alternative to institutional care. While this may be the case in some instances, it is not the rule, especially in those individuals who have serious deficiencies in activities of daily living. Even Bruce Vladeck, the Administrator of the Health Care Financing Administration, recently noted a concern about the misconception that home care is less expensive than care in an institutional setting.

Finally, we are disturbed with the Administration's plans to cap this new entitlement. What happens if the funds are exhausted? Will it be the states' responsibility to continue to support the recipient of service, or will the provider be caught with another uncompensated care bill? AAHA would like to see these issues addressed adequately, as Congress begins its deliberations on health care reform.

Rationale for AAHA Approach

AAHA's modified social insurance approach is based on the principle that private financing should be contributed by those with the ability to pay for long-term care services and public resources should be preserved for the most needy. AAHA defines the most needy as those who incur catastrophic expenses for long-term care and those who cannot afford even short-term care due to economic circumstances. Since short-term nursing home stays and supportive services constitute smaller risks than extensive nursing home stays, AAHA proposes that these costs be self-financed through income or private insurance coverage. Since long-term nursing home stays would represent a catastrophic expense for the majority of the population, AAHA proposes that the Federal government finance these costs through insurance. We believe that, in general, the Administration's plan for long-term care recognizes the importance of this partnership between the private and public sector. AAHA believes that this principle should be part of congressional consideration of a long-term care benefit package.

We also believe that the back-end approach to social insurance would be the most complementary to a public/private sector partnership by providing strong incentives to self-insure for short-term and lower-cost services. Clearly cost is a major deterrent to the purchase of private insurance coverage. Limiting exposure to shorter-term nursing home stays and supportive services would make private insurance less expensive and more individuals would be likely to purchase coverage. For example, a two-year nursing home policy would cost the average purchaser about \$700 annually.

There are distinct marketing advantages to short-term private insurance coverage. If the federal government financed catastrophic nursing home risk, individuals would be required to purchase only the amount of coverage required to fill the gaps in federal protection. This is the principle behind Medicare supplemental insurance for acute care expenses which is owned by about 70 percent of the over 65 population. If coverage for the nursing home deductible period and supportive services were linked to Medicare supplemental insurance policies, barriers to the marketing of private policies could be reduced. AAHA believes that those with Medigap coverage would be more likely to expand existing policies to include a year or two of nursing home coverage than they would be to buy a separate individual policy covering only long-term care insurance benefits.

CONCLUSION/SUMMARY OF OBSERVATIONS

AAHA has long contended that the public and private sectors must forge a strong partnership to effectively expand access to services and provide adequate financing for the long-term care population. We are encouraged with the overall direction of the President's plan to reform our health care system. In particular, AAHA urges the Congress to consider the following issues and recommendations in reforming the nation's long-term care programs:

- o Medicare should be expanded to fund nursing home care after an initial deductible period of 12-24 months. Individuals with long nursing home stays are at greatest risk of spending down their resources and

becoming eligible for Medicaid at great expense to the federal and state governments since public assistance benefits are not prefunded. Extended care benefits should remain an integral part of the basic benefit package.

- o Medicaid should continue to provide coverage to those who cannot self-fund the nursing home deductible period and/or pay for home and community-based care. Furthermore, states should have flexibility in using Medicaid funds to pay for a variety of chronic care services provided in any setting from the community-at-large to senior housing and residential care facilities. Such flexibility would allow states to provide care more cost effectively and provide services to a larger population with the same dollars.
- o Nursing home costs are driven by regulations that often bear little relationship to quality of care or resident outcomes. Nursing home payment is driven more by state budget needs than an accurate assessment of the costs involved in providing quality care. These trends must be reversed with payment rates based on a reasonable estimate of the costs incurred in meeting regulatory requirements and providing high quality care.
- o Senior housing programs offer a cost-effective alternative for many older people. They also contribute to significant cost savings in other federal programs such as Medicaid. Federal rental assistance allows many seniors to remain in independent environments and pay for care that otherwise would be funded by the Federal and state programs.
- o The Federal government should enact minimum standards regarding long-term care insurance policies to ensure coverage of basic benefits, promote greater consistency across products to aid consumers in comparison shopping and to protect consumers by assuring the financial stability of products and markets.
- o The Federal government needs to clarify that long-term care insurance will be treated like health insurance under the tax code, providing economic incentives to sponsors and purchasers of these products.
- o Education about long-term care is vital. There continues to be significant misunderstanding regarding long-term care risk and the resources available to protect against this risk. The public continues to overestimate the amount of long-term care coverage provided under Medicare, but also tends to underestimate the value and affordability of private insurance policies. The public sector has a responsibility to correct both of these mistaken perceptions.
- o Finally, the public sector can make valuable contributions by promoting and supporting demonstration projects at the federal, state and local levels regarding long-term care financing and delivery as outlined, in part, in the Administration's plan. Below are some areas that should be explored:
 - models for integrating acute and chronic care services;
 - senior housing and residential care programs that provide supportive services for the frail elderly through the collocation of housing and supportive services, the establishment of long-term care provider networks, etc.;
 - greater flexibility in the use of Medicaid funding for supportive services; and
 - pooling resources across a wide range of public and private sector programs to reduce barriers to care and increase the cost-effectiveness of delivery.

AAHA's Long-Term Care Reform Plan represents a two-year effort among AAHA members to develop a consensus plan addressing the needs of providers and residents across the continuum of residential and health-related delivery

settings. Our "Partnership in Caring" attempts to create a public/private partnership combining the most complimentary roles for each sector. AAHA believes that the public sector has a fundamental responsibility to both provide for the needy and create the incentives necessary to promote private sector programs for the financing and delivery of long-term care services. Those in the private sector must take advantage of these incentives and plan for their future long-term care needs.

The demographic imperative is upon us. We must take the steps necessary to develop the kind of financing and delivery infrastructure capable of accommodating the needs of a burgeoning elderly population. The President's "Health Security Act" is a major step in the direction of more rationally meeting these needs. AAHA stands ready to assist the Congress as it continues the task of reforming our nation's health programs.

Chairman STARK. Mr. Thorpe.

STATEMENT OF RICHARD L. THORPE, EXECUTIVE VICE PRESIDENT, AMERICAN COLLEGE OF HEALTH CARE ADMINISTRATORS

Mr. THORPE. Thank you, Mr. Chairman.

I am Richard Thorpe, executive vice president of the American College of Health Care Administrators. I speak to you today on behalf of our membership as well as the more than 50,000 long-term care administrators across the Nation whose interest the college represents.

We are pleased to see that long-term care has been included in the President's package for health care reform. We are encouraged that the important role played by nursing facilities in the continuum of care has been recognized by this committee. We are also enthusiastic about the opportunities in long-term care, including services in the home and community, independent and assisted living as well as subacute and skilled facilities. However, we are concerned that additional cuts to the Medicare and Medicaid programs will have a negative impact on our ability to provide high quality care. Further cuts in these entitlement programs will place an undue burden on some of the most vulnerable segments of our society.

The college enthusiastically supports the role of long-term care insurance. This offers an alternative that would prevent individuals from being forced to deplete their own assets as well as alleviates the need for reliance solely on government-funded programs. We additionally support the concept of medical IRAs and tax protected savings accounts, allowing individuals to anticipate and plan for their long-term care needs.

While the administration has recognized that long-term care is a key component of any effective health care delivery system, we submit to you that the maintenance of high standards and ethics is crucial to the provision of these services. In order to guarantee the highest quality of care, long-term care administrators should comply with uniform standards of practice rather than a fragmented State-by-State system.

We are concerned by the current sentiment that national license should be eliminated. How can we guarantee high quality long-term care without uniformity of standards? There is a need for a nationally recognized certification program for administrators that would be used as a credentialing process for determining advanced professional competency. This will enable us to assure that the special population we serve will receive the best possible care.

In restructuring the health care delivery system, it is crucial for nursing facilities to explore wider avenues of service provision to residents requiring care at varied levels. In addressing the full continuum of cases, the health care community needs a definition of subacute care. It is important to recognize that the primary function of nursing facilities is the provision of skilled nursing of which subacute care is an intrinsic part. Nursing facilities are uniquely qualified to provide this care. While hospitals are focused on cure, nursing facilities are geared to providing care that maintains or rehabilitates residents to regain activities to partake in the normal

activities of daily living. Not only is our staff better equipped with their specialized training, but our facilities are able to offer these services far more cost-effectively than any other provider.

In closing, the college asserts that the financing of long-term care should not be funded primarily through cuts in the Medicare and Medicaid programs but that individuals should be provided incentives to plan for their own potential long-term care needs in order to best meet the needs of the elderly, chronically ill, and disabled. Facilities must receive sufficient resources to continue to provide the highest level of care spanning the full continuum.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mr. Thorpe.

[The prepared statement follows:]

**Health Subcommittee
Ways and Means Committee, U.S. House of Representatives
The President's Health Care Reform Proposal
Long-Term Care Issues
November 2, 1993**

**Testimony of Richard L. Thorpe, CFACHCA, CAE*
Executive Vice-President
American College of Health Care Administrators**

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to testify today. I am Richard Thorpe, Executive Vice-President of the American College of Health Care Administrators. I speak to you today on behalf of our membership as well as the over 50,000 long-term care administrators across the nation whose interests the College represents.

We are pleased to see that long-term care has been included in the President's package for health care reform. We are encouraged that the important role that nursing facilities play in the continuum of care has been recognized by this committee. We are also enthusiastic about the opportunities that will arise with the emphasis the administration has placed on all aspects of long-term care including services in the home and community, independent and assisted living, as well as sub-acute and skilled facilities.

Proposed Methods of Financing

We are concerned, however, with some of the proposed methods of financing. We feel that additional cuts to the Medicare and Medicaid programs will have a negative effect on our ability to provide high quality care. We've done so much, for so long, for so many, with so little that these proposed cuts send us the message that ultimately we will be expected to do everything, for everyone, for ever, for even less.

The College is also concerned that further cuts in these entitlement programs will place an undue burden on some of the most vulnerable segments of our society--the disabled, chronically ill and elderly. The College enthusiastically supports the role of long-term care insurance but it must be a reasonably priced option so individuals may plan ahead, for what could potentially be, devastating costs down the road. Long-term care insurance offers an alternative that would prevent individuals from being forced to deplete their own assets, as well as alleviate the need for reliance solely on government-funded programs. Additionally, we support the concept of medical IRA's and tax protected savings accounts for individuals to anticipate and plan for their long-term care needs.

Quality of Care

While the administration has recognized that LTC is an integral part of any effective health care delivery system, we submit to you that maintenance of high standards and ethics is crucial to the provision of these services. In order to guarantee the highest quality of care, long-term care administrators should comply with uniform standards of practice, rather than a fragmented state by state system. We are concerned by the current sentiment that national licensure be eliminated. How can we guarantee high quality long-term care without the uniformity of national standards?

There is a need for a nationally recognized certification program for administrators that would be used as a credentialing process for determining the advanced professional competency of administrators. This would enable administrators to ensure that the special population we serve will receive the best possible care. Long-term care administrators who are members of the College voluntarily adhere to a strict Code of Ethics and Standards of Practice that reach far beyond that which is required by any state or federal regulation. The College offers all administrators a nationally recognized certification program to enhance professional skills. We feel this should be the standard not only for College members, but for every administrator in both skilled nursing and assisted living facilities.

The Continuum of Care

The long-term care industry assists and facilitates the recovery of functional ability in its residents and patients. The restructuring of the delivery system in the continuum of long-term care makes it crucial for nursing facilities to explore wider avenues of service provision to residents requiring care at varied levels.

In addressing the full continuum of care, the health care community needs a clear definition for sub-acute care. It is important to recognize that the primary function of nursing facilities is the provision of skilled nursing, of which sub-acute care is an integral part. Nursing facilities are uniquely qualified to provide this care as they are better structured to provide long term intervention. While hospitals are focused on cure, nursing facilities are geared toward providing care that maintains or rehabilitates residents so that they may regain their ability to partake in the normal activities of daily living. Not only is our staff better equipped, via their specialized training, to aid in the restoration of these skills, but facilities are able to offer these services far more cost-effectively than any other provider.

Conclusion

In closing, the College reiterates its assertion that the financing of long-term care should not be funded primarily through cuts to the Medicare and Medicaid programs, but that individuals should be given incentives to plan for their potential long-term care needs. Additionally, we feel that our patients and residents should be provided with the highest possible quality of care and believe this can be achieved by implementation of a national licensure and certification requirement for facility administrators. Finally, in order to best meet the needs of the elderly, chronically ill and disabled, facilities must receive sufficient resources to continue to provide the best level of care that spans the full continuum.

Thank you.

*Certified Fellow of the American College of Health Care Administrators and Certified Association Executive

Chairman STARK. I have long been concerned about how we write into law requirements that nursing homes provide tender loving care and that sort of thing. It is a very illusive thing. But I am intrigued by your certification program. Give me an idea of, for instance, the educational requirements to become a CFACHCA.

Mr. THORPE. Let me define the CFACHCA. Certified and Fellow are the first two letters of that acronym. Certification is the program, Mr. Chairman, that you have questioned. It is a voluntary credentialing program offered to all administrators nationwide that we believe evidences a professional demeanor for administrators that really applies to the quality of care. In terms of its criteria, the baccalaureate degree is required and 2 years of experience as a licensed long-term care facility administrator. And there are a number of other requirements to that.

Chairman STARK. Any old baccalaureate degree?

Mr. THORPE. Any baccalaureate degree and 2 years of experience.

Chairman STARK. Do all States license administrators now?

Mr. THORPE. Yes, Mr. Chairman, currently all States license.

Chairman STARK. And then you have a Code of Ethics?

Mr. THORPE. Yes, Mr. Chairman. The American College of Health Care Administrators is founded on an ethical code which we believe subscribed to a higher level of ethical performance.

Chairman STARK. All right. And you have some kind of a review procedure, a testing or an interview or a form to fill out?

Mr. THORPE. Members of the college are required to subscribe to the Code of Ethics. When they join, they all receive copies of it. We proudly display it in our facilities. It has both prescriptive and proscriptive elements.

Chairman STARK. But you don't test people? You don't have to go through a series of courses and pass a certification by a board of reviewers?

Mr. THORPE. We do have an independent certification body that is independent of the college that does review the criteria as well as the passage of a national examination for certification.

Chairman STARK. Could you send me an old exam? I won't sell the questions to a new crop of applicants, but it would help us as we look for ways to establish standards because that is an area that hasn't had a lot of work.

Mr. THORPE. We would be pleased to provide the committee with all of that material.

Chairman STARK. I would love to see it.

[The information is being retained in the committee files.]

Chairman STARK. Mr. Rodgers, you bring up this back-end social insurance. Would the rest of you be comfortable with Mr. Rodgers' approach of having the Federal Government underwrite or set the minimum long-term standards, say, after 2 years? Arguably, the States could do more if they chose, and then allow a variety of programs for the first 2 years, whether it is private insurance or a variety of State programs. Would you have an objection to that?

Mr. WILLGING. We actually, 3 or 4 years ago, Mr. Chairman, were supporting that basic approach. Basically, the legislation that Senator Mitchell introduced in the Senate, the so-called "stop loss provisions." That was before we actually costed it out and we discovered that whether you do front-end coverage with public funding

or back-end, the cost implications are horrendous. The reasons being under either scenario you are certainly using public funding for those who up to that point have been using their own private payments, which is why we have moved to a parallel track approach to say that we need to augment, enhance, and improve the safety net of the Medicaid program but stimulate the use of private sector mechanisms for those who have the resources to purchase those mechanisms, such as long-term care insurance.

Chairman STARK. But, arguably, that is 20 percent of the population.

Mr. WILLGING. I followed with interest the discussion with the representative from HIAA and I am not sure it is 20 percent of the population. I have looked carefully at the studies which suggest that long-term care insurance is not affordable to a good portion of the elderly population. And I find much—

Chairman STARK. The young population. To heck with the elderly.

Mr. WILLGING. Well, I find, though, that many of those arguments become self-fulfilling prophecy. One of the studies posited three hypotheses: One, that no one would spend money for long-term care insurance if their income was less than \$25,000; two, they would not dip into liquid assets and; three, they would not pay more than 5 percent of their income on long-term care insurance. And based on that, the end result was that only 5 to 20 percent would purchase it.

But if you take those same three assumptions and apply it to medigap insurance, you would find that only 5 to 20 percent of Americans would buy it, yet 70 percent do buy it.

I am suggesting that the problem that we have had in terms of rapid sales of long-term care insurance is the question of value. As long as people don't understand the potential for long-term care and there is an assumption that at some point the government will pass a program and up until the budget bill of this year, as long as they felt they had the option of artificially impoverishing themselves through asset transfer, the value was not perceived. So the question of affordability is a tricky one. And I know that I disagree with many of my colleagues. Mr. Wiener and myself have had this debate for a number of years but I think that the question of affordability warrants more discussion.

Chairman STARK. I would be glad to discuss it until you are blue in the face.

Mr. WILLGING. Not that long, Mr. Chairman.

Chairman STARK. But you have a big job when most people in every other area of their lives are underinsured, be it life insurance or savings for retirement or a whole host of issues. Why you could make the case that somehow you are going to have a lot of educating to do to scare people much worse than your friendly life insurance salesman can do already. How many presentations do you want to see with widows standing in the rain burying the old man while the kids see the vision of their college—they still don't buy life insurance. And it probably is not a very good investment, as has been suggested. And there certainly would be no better investment for a young person to establish than an investment fund. But I would submit to you that the discretionary income needed to pur-

chase this stuff, if you assume that people are going to take care of the daily costs of living, shelter or food, transportation, clothing, a little bit of recreation—now if you are the school of the great former Mr. Sullivan who believes in celibacy, exercise, abstinence and prayer as a way to solve the health care—the Republican litany—be my guest. But in the realities of selling insurance, I don't think you can make the case. And studies notwithstanding, they haven't done it.

Mr. WILLGING. But I wonder if we have really tried, Mr. Chairman.

Chairman STARK. Have you been called on by those clowns? Do you have any relatives that sell insurance?

Mr. WILLGING. I look at the data that suggests that 40 percent of the American population assumes that their liability for long-term care is going to be covered by either their private insurance product or by Medicare or Medicaid.

Chairman STARK. Well, it will be covered in many cases by Medicaid. If you are broke, it will cover you.

Mr. WILLGING. But the American public is unaware of its potential liability. And I think one of the intriguing parts of the President's proposal is the approach to education; the second being consumer protection; the third being tax clarifications. But as long as 40 percent of the American public is not aware of potential—

Chairman STARK. You know what those three things get you? A big nothing. Education, tax incentives, my God. That is to say, let's not be troubled with it and let's not pay for it. If we are going to talk about education and tax incentives for people who don't have insurance or can't afford it, we are wasting our time and your industry certainly is, too. If you want to trade that for Medicaid benefits—do you think your industry could survive? I will make that deal with you in a minute and you wouldn't dare.

Mr. WILLGING. No, I wouldn't.

Chairman STARK. Of course you wouldn't, your industry wouldn't exist without Medicaid. And this idea that suddenly there is some way out there that some way the private is going to pull a rabbit out of a hat, I think it begs any insurance that this country has seen.

Mr. WILLGING. I sense we may have a philosophical difference here, Mr. Chairman.

Mr. RODGERS. I think one of the reasons why we looked at a stop-loss measure was because there would be a defined period of time that people would have responsibilities for or could use individual assets to fund long-term care insurance. At least there would be some defined liability period that they would have to meet prior to receiving benefits of the Federal program.

Chairman STARK. I find that great minds go in the same direction, Mr. Rodgers.

Mr. THORPE. If I could add to that. I believe that the public and private partnership, which we have talked about a number of times, has to be a complementary relationship.

Chairman STARK. But you believe in Medisave accounts. Didn't you say something about that?

Mr. THORPE. I believe in medical IRAs. I believe in tax protected savings accounts, specifically targeted for—

Chairman STARK. You are not even in this discussion, Mr. Thorpe. Excuse me.

Mr. THORPE. But what I was referring to was the insurance issue.

Chairman STARK. I hear, but that is why I avoided asking you about it because it isn't worth discussing. I share Mr. Rodgers' viewpoint that we have to recognize that this is a social program. I believe that it will be a race to see who is the second last Nation in the world, us or South Africa, to not provide this kind of care to its citizens, and I would like to see us not be last in that race.

And I think you approach it properly. There are probably a few citizens who could afford to pay for long-term care. They really don't need anything. I mean, I would say that most Federal employees, military officers with 20 years or more, anybody that can look forward to somewhat substantially more than \$40,000 or \$50,000 a year retirement income is home free. They can go buy insurance, be my guest. Or invest with the Prudential security salesman if they trust him and they liked the way he has handled their investment account, then trust the same guy to sell you health care and good luck. But in the meantime, I think that for the two-thirds of the American public that, one, can't afford it, and, two, would, I think, be sold long-term care insurance to their detriment, that we have to face up if we are going to provide it.

And I like the idea of a continuum of care. I agree with you. There is no sense making these people the stepchildren of our benefits, that it should be an integrated care and part of the continuum of care.

Do you know of any either HMOs or preferred provider organizations—I have a vague idea that they do something like this either in Rochester or Minnesota—where there is a large group of people in some kind of capitated program and managed care program where long-term care is part of the whole package?

Mr. RODGERS. Yes, the social health maintenance organizations are excellent examples. Mr. Chairman, one operates in your State.

Chairman STARK. Where?

Mr. RODGERS. I believe it is in the Long Beach area. There is one in Portland, Oreg., in Minneapolis, Minn., and the other one is in New York City.

Chairman STARK. Can you describe it? Where does somebody enter this operation?

Mr. RODGERS. This is not an offshoot of a TEFRA HMO capitated program under Medicare.

Chairman STARK. It starts with Medicare? You don't start earlier in the program in your employed years?

Mr. RODGERS. I am not certain about that, Mr. Chairman, but I know that prospective patients would utilize their Medicare dollars to buy into the health maintenance organization. A difference between this type of organization and the social health maintenance organization is the social care components or the long-term care component. While LTC services limited, it is clearly a step in the right direction.

The one thing that is problematic, however, in at least two of the sites concerns the financing. At the Minneapolis and the Portland sites, they have become so efficient in the delivery of managed care

services that their annual adjustment cost factors have been artificially depressed. Another factor is that as part of the agreement to enter into this social health maintenance organization system, organizations have to take all comers. And since they have a fairly large percentage of impaired and frail elderly, they are finding that their costs for meeting their patients' needs have been escalating. I think we need to examine these financing concerns more closely.

Chairman STARK. In these systems, as part of some kind of capitated program for the Medicare beneficiary, a gate keeper makes the decision as to whether you should be moved into a skilled nursing facility or a long-term care facility or whether you can be removed from that and whether you can have a certain amount of assistance in your home.

Mr. RODGERS. There is clearly a managed care component.

Chairman STARK. And they take an inventory of your resources, whether you have children living in the area and all of these and ground some kind of a decision process and then the case is managed seamlessly?

Mr. RODGERS. That is my understanding. Although, as I said, I think the long-term care benefit itself is somewhat limited. And an individual can eventually spend down and be required to utilize Medicaid resources to fund long-term institutional care.

Chairman STARK. Is this just an experiment gate keeping or are they actually funding it so that the charges or the Medicare risk contract payment plus something else covers it, anticipating they have to pay to use Medicaid at some point? I mean, this is a complete program that is self-financing?

Mr. RODGERS. It is a complete program. It is part of the TEFRA Medicare HMO enacted by Congress several years ago.

As I pointed out, however, two of the social health maintenance organizations are experiencing some financial difficulty because of the level of chronicity of some of the older people that are part of their systems. In situations like these, HCFA may have to go back to make adjustments for these kinds of factors. This presumably would be part of the managed computation approach that the administration is thinking about.

Chairman STARK. Is there an open enrollment sort of feature so that there is an opportunity for adverse selection here? Is it the sort of thing—

Mr. RODGERS. I think this is one of the reasons why both of those programs, the one in Minneapolis and Portland, are experiencing difficulties because there was an open enrollment.

Chairman STARK. So if mom gets sick and she is 80-years-old, it is time for her to join the social experience and quit going to Mr. Jones on a fee-for-service basis?

Mr. RODGERS. I'm uncertain on the specifics of the program. I will have to get you more information on that, Mr. Chairman. I will be glad to provide that to the committee.

[The following was subsequently received:]



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November 22, 1993

The Honorable Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
1114 Longworth Office Building
Washington, D.C. 20515

Dear Chairman Stark:

The American Association of Homes for the Aging (AAHA) was privileged to testify recently before your Subcommittee on Health of the Ways and Means Committee on the President's Health Care Reform Proposals. During the question period we shared information on the HCFA social health maintenance organization (SHMO) demonstrations, which may offer important lessons for health care reform. As promised to the Subcommittee, we submit this letter and attached background as additional information on the concept of social HMOs. It is our pleasure to have the opportunity to do so.

The SHMO is a public-private health care model that integrates acute care and home and community based long-term care while maintaining budget neutrality. The four sites of the demonstration projects are the Elderplan in Brooklyn, N.Y; Kaiser Permanente Medicare Plus II in Portland, Oregon; The SCAN Health Plan in Long Beach, CA and Seniors Plus in Minneapolis, MN. The sites in Minnesota and New York are AAHA members.

The SHMOs are good examples of systems that can be implemented that establish a satisfactory continuum of care by integrating not only institutional care and home and community services for the disabled elderly but also our acute care and long-term care systems. SHMOs have shown success in expanding benefits without additional expense.

In Minnesota and Oregon, the SHMOs have experienced hardships due to the increasing patient acuity and the limited increase of state-specific Medicare rates based on the method called the "average adjusted per capita cost" (AAPCC). The Minnesota and Oregon sites are losing incentives to participate in these managed care environments because they are not obtaining equitable payment through the AAPCC.

The attachments were selected to give you background on the operational aspects of these demonstrations and observations to date on their status. If you or the Subcommittee have specific questions on SHMOs, please do not hesitate to call upon us. Both our members and staff are available to provide you with written information or to meet with you or your staffs. Thank you for the opportunity to testify before your committee and provide this additional information.

Sincerely,

Michael F. Rodgers
Senior Vice President

Attachments

SOCIAL HMOS ARE PROVIDING LESSONS FOR HEALTH REFORM

Prepared by Brandeis University and Social HMO Consortium

I. SUMMARY OF THE SOCIAL HMO MODEL AND STATUS

The Social HMO is a public-private health care model that integrates acute care and home/community based long-term care (LTC) while remaining budget neutral. Social HMOs pool premiums from Medicare, Medicaid and members to create prepaid, managed health and LTC systems that are competitive in the Medicare supplement and HMO market. After eight years of operations, all four test sites are financially sound and delivering coordinated acute and LTC services to a total of 22,000 current members.

Without increasing public spending and at affordable rates to members, Social HMOs cover, and usually far exceed, all Medicare acute benefits, add prescription drugs, and cover up to \$1,000 per month in home/community based LTC -- including personal care, homemakers, nursing and therapies, adult day health, short-term nursing home care and support services. Not restricted by Medicare home health and skilled nursing facility criteria, these LTC benefits are available to members who meet nursing home pre-admission screening criteria -- currently between 5% and 20% of memberships at the four sites. Only long-term nursing home coverage is excluded. This LTC benefit structure is thus similar to that proposed by the Clinton Administration.

The development of the Social HMO model has been led by the Brandeis University Health Policy Institute, but the project has many supporters. In 1980 the Health Care Financing Administration funded initial planning. In 1982 four test sites began development with support from more than 20 foundations and corporations. Since then, four acts of Congress have mandated, extended and expanded the program; and nearly 30,000 Medicare beneficiaries have been served.

The four test sites are Elderplan in Brooklyn, NY; Kaiser Permanente Medicare Plus II in Portland, OR; the SCAN Health Plan in Long Beach, CA; and Seniors Plus in

Minneapolis, MN. Brandeis continues to lead the development of the Social HMO model by coordinating the direction of the four sites through the Social HMO Consortium and by designing the expansion to four additional sites under a grant from HCFA. The Social HMO Consortium has built and maintained a research database on the utilization and health status of this population.

II. THE SOCIAL HMO AND HEALTH CARE REFORM

The Social HMOs have four design features that should be considered in health care reform:

(1) Use home/community LTC to enhance medical care: Most community LTC programs have been conceived too narrowly as social support only. Although personal and household support may predominate in resource use, in an integrated system, community LTC can yield more benefit:

- * by supporting medical care by making sure appointments are kept, medical regimens (e.g. diets, medications) are followed and that emergent problems are spotted and reported.
- * by fostering a geriatric approach to acute care by providing the resources to implement multidimensional care plans.
- * by managing transitions across all levels and settings of care rather than stopping at the borders of acute and skilled care.
- * by screening nursing home applicants and diverting some patients to home care, thus enhancing the options for hospital discharge planners.

(2) Finance and market home/community LTC with medicare care: If health care reform is to meet its goals for universal access and community rating, it will need to find methods to compensate provider/insurer systems that enroll disproportionate numbers of frail and acutely ill beneficiaries. One piece of the solution for ensuring service to the disabled is to embed a chronic care perspective in the financing, marketing and reimbursement for acute care itself.

Social HMO costs for community LTC have averaged between \$30 and \$40 per member per month (PMPM) across the membership during 1985 - 1990. These costs, which include case management, are far less than prior LTC demonstrations or

estimates in other national LTC reform proposals. Serving 10% of the aged with this benefit would cost less than half of the Pepper Commission estimates for service a much narrower (3 ADL) population. Prescription drug benefits add another \$30 to \$40 PMPM.

Public/private financing, community rating and consumer choice could be built into an integrated, comprehensive system of acute and LTC:

- * by incorporating a disability-based actuarial factor into prospective reimbursement formulas (which Social HMOs have done on a demonstration basis).
- * by adding public funding for at least some of the \$60 to \$80 per beneficiary per month for prescription drug and community LTC coverage.
- * by asking beneficiaries to pay the balance through premiums.

(3) Target community LTC more broadly than the permanently disabled: Most other LTC reform proposals would develop a stand-alone LTC system – segregated from Medicare acute and skilled care – designed to provide community LTC for the permanently and severely disabled. Such a segregated system assumes that disability and acute illness are separate phenomena. In fact, skilled care patients are often frail, and the frail aged often need skilled care. Therefore, Social HMOs were designed to integrate the management of all community and nursing home care whether these services meet Medicare or LTC criteria, and whether a beneficiary is disabled permanently or temporarily.

Social HMO research shows that eligibility for and use of skilled and LTC benefits overlap extensively. Most LTC referrals come from the medical system (particularly hospitals), and a quarter of non-disabled hospital users become disabled after discharge. Furthermore, many of the disabled eventually recover independence, particularly those who have recently been hospitalized. Linking community LTC to the acute care system serving all beneficiaries is the only way to efficiently pick up these new referrals, supplement the skilled care benefits as needed, continue for as long as support is needed and terminate benefits when appropriate.

(4) Protect older people from institutionalization and impoverishment: When people use virtually all of their income and assets to pay for uncovered medical care

or LTC, they have "spent-down" and can apply for Medicaid. A study has shown that the Social HMO's complete coverage for preventive and acute care, prescription drugs and LTC reduces medical spend-downs. Case management, ongoing community LTC and short-stay nursing home coverage beyond Medicare help members delay or avoid permanent nursing home placement, the major source of spend-down. These were goals of the Medicare Catastrophic Coverage, the Pepper Commission and of the current Clinton proposal, and they could be realized through expansion of Social HMOs or similar integrated acute and LTC service systems.

For further information, data, and readings, contact Walter Leutz, PhD, Director, Social HMO Consortium, at the Brandeis University Institute for Health Policy, Waltham MA, 02254. (617) 736-3934.

THE MINNESOTA EXPERIENCE

What have we learned?

Taken from "Minnesota Medicare Demonstration Concept Paper"
April 1993 draft, written by the Minnesota Council of HMOs.

Minnesota has a solid history of leadership and innovation in managed care and health system reform. The state's regulatory agencies, and the health plans are national leaders in both Medicare and Medicaid programs. Minnesota HMOs have helped to develop and test the Medicare risk contracting program since its inception. The HMOs have clearly demonstrated the competitive market potential of prepaid plans, positively and significantly impacted community-wide costs in the commercial and Medicare markets, experimented with risk-adjusted payment, and attempted to bring the benefits of comprehensive care and capitation to the rural areas of the state. The risk contracting programs in Minnesota were highly successful for almost a decade -- expanding access to care at significant financial savings to beneficiaries while reducing the rate of growth in total Medicare spending to significantly below the national average as measured by both per capita costs and annual rates of increase.

However, over the past several years, we have begun to backslide and reverse the progress of the last decade, as AAPCC-based reimbursement has fallen significantly behind the plans' medical cost trends for the senior populations. One-by-one most of the risk contracting HMOs have converted to Health Care Prepayment Plans (HCPPs) or supplement-only plans in response to the systematic underpayment to the community relative to less efficient markets through the Average Adjusted per Capita Cost (AAPCC) method. From a high point of over 32% of all seniors state wide having been enrolled in five Medicare risk plans in 1987, there is now only two risk contractors remaining, enrolling 11% of seniors, all of whom are in the metro area. These conversions have occurred at significant cost to the government, and to beneficiaries, as the efficiencies of managing both Part A and Part B spending together have been lost. (Attachment 1).

These enrollment conversions were necessitated by multi-million dollar losses for the HMOs under their Medicare risk contracts, even though the plans' sizes were substantial and their efficiency and operating

competency well established in what is arguably the most sophisticated health care market in the nation. A number of studies have documented the efficiency and cost-effectiveness of the Twin Cities as measured on a number of dimensions relative to other major metropolitan areas (Attachment 2). It is believed that the evidence is compelling that HMOs have had a commitment role in producing these results.

In the TEFRA risk contracting program, plans have become "the victims of their own success" in having helped to reduce Medicare expenditures. The 1993 AAPCC in Hennepin County (Minneapolis) is \$353 per month, which is 98% of the national average for all counties and about 89% over the urban average. Hennepin's 1993 AAPCC rate increased 7.8% over 1992, in comparison with the 13.3% national average increase. The contrasts between the Twin Cities and other major areas on AAPCCs, annual increases, changes in the relationship of the AAPCC to the USPCC, and the ration of Part A to Part B are shown in Attachment 2.

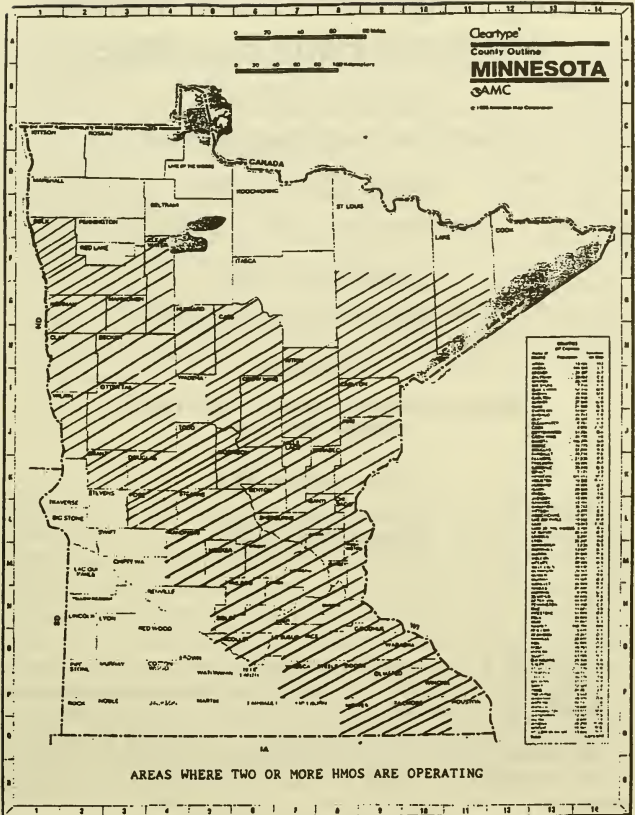
The relevance of the Minnesota risk contracting experience to Medicare's national cost and quality improvement strategies, and to health care reform overall, is striking. Risk contracting HMOs are essential "accountable health plans" (AHPs) as envisioned by Clinton's reform proposal. The Minnesota experience shows that AHPs can indeed be capitated/budgeted, produce measurable results, be very attractive to consumers, and lead in restructuring care delivery system-wide for greater efficiency and quality. However, the Minnesota experience also clearly demonstrates that for the AHP reform strategy to be broadly successful nationwide, and sustainable over time, geographic payment inequities need to be addressed and efficient plans and communities must be rewarded rather than dis-incented for their success.

Medicare Risk Product Contracting History

HMO	Risk Contracting History	Current Medicare Program	
		Contract	Enrollment
Blue Plus	1985 - 1990	HCPP	13,613
Group Health, Inc.	1985 - 1993	Risk/SHMO	22,632
MedCenters	1985 - 1991	HCPP	13,742
PHP	1986 - 1989	HCPP	40,405
Share	1986 - 1993	Risk	38,950

MAP #2

MINNESOTA



Adding Long-Term Care to Medicare: The Social HMO Experience

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ABSTRACT. The rancor accompanying the repeal of most of the 1988 Medicare Catastrophic Act reflects both the national need to improve health and long-term care benefits for the elderly and the political obstacles to finding new sources of financing for such benefits. Neither the need nor the obstacles will go away, but policymakers are now likely to look for lower-cost, efficient, and privately

The Social HMO Consortium is a cooperative venture of the four demonstration sites and Brandeis University to conduct research and policy analysis in the public interest and the public domain.

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funded alternatives. The authors have developed and tested one such approach: the Social Health Maintenance Organization (SHMO). Operating since 1985, the SHMO model integrates community-based, long-term care services into the managed, prepaid HMO design. The four test sites are adding long-term care to Medicare at no extra cost to the government and only modest premiums for the 17,000 current members. Although the benefits offer limited protection for long-term nursing home care, they do cover long-term care in community settings, where people tend to prefer to stay. Also, integration of the acute and long-term care systems improves the ability to respond to the medical needs of frail members, who also have high acute-care use. The SHMO's model of front-end, community-oriented, long-term care benefits integrated with Medicare appears to be a practical, affordable, and clinically appropriate way to address the rising concern with the lack of coverage and services for long-term care.

AN OVERVIEW

Probably the most glaring omission in the now-repealed health care benefits for the elderly represented by the Medicare Catastrophic Illness Act of 1988 (P.L. 100-360) was coverage for long-term care—in both nursing homes and home-based and community-based settings. Given the conspicuous need for such coverage, the omission is only slightly less surprising than the Reagan Administration's proposal of the measure in the first place, and appears to have been a factor in the repeal of much of the new coverage. While the inclusion of long-term care had its champions during the drawn-out congressional process—chiefly House Democrats responding to pressure from the American Association of Retired Persons (AARP)—the final judgement was that a long-term care benefit would prove both too difficult to manage and too costly (Iglehart, 1989). Without underestimating the political clout of the elderly and their several lobbies, therefore, it would seem that the burden of devising alternative ways to finance and deliver long-term care will continue to fall to the states and the private sector.

Numerous demonstrations over the past decade have attempted to quantify the benefits of home- and community-based long-term care for the elderly and to assess its costs—this on the assumption that such care could save money by substituting for institutional care. While many of these studies have shown that long-term care ser-

vices for disabled elderly in the community could be increased, such services have usually raised overall health care service costs and have seldom reduced hospital or nursing home use or improved patient outcomes enough to offset new spending (Capitman, 1989; GAO, 1982; Kane & Kane, 1987; Weissert, Cready, & Pawelak, 1988). One suggestion has been to forget about cutting costs and to expand home and community care services simply because of the peace of mind they provide to the frail elderly and their caregivers (Kemper, Applebaum, & Harrigan, 1988). This argument—if we can't save money, let's at least buy greater satisfaction for our dollar—is not without merit, though it may be premature.

Turning to the positive outcomes of the various demonstration findings, we note that policymakers have indeed found a cautious way to expand Medicaid benefits in the 2176 waiver program, which allows states to offer community long-term care services to the poor as an alternative to nursing home care (Laudicina & Burwell, 1988). Still, Medicare experiments have so far yielded little in the way of new community long-term care benefit programs available to the general Medicare population. Of the many experimental models tried, only two have stood the test of time, both under congressionally mandated Medicare and Medicaid waivers: the OnLok demonstration in San Francisco, which is in the process of expanding to six sites (Zawadski & Eng, 1988), and the Social Health Maintenance Organization (SHMO) (Leutz et al., 1985), whose four sites have been in operation for six years, and which will soon be expanded to four more sites.

The OnLok and SHMO models have survived because they overcome many shortcomings of other Medicare experiments. Both build on Medicare Health Maintenance Organization (HMO) features of a risk-adjusted Medicare capitation, integration of acute and long-term care services, and provider risk. Both are also budget-neutral, surviving on modifications of current reimbursement rather than requiring new public financing. The SHMO adds the additional HMO advantages of being open to all beneficiaries (rather than only to disabled Medicaid eligibles, as in OnLok), using open enrollment in the competitive marketplace, and creating pooled public-private financing.

After four years of operation, all four SHMO sites have survived at full financial risk, created a significant new long-term care enti-

tlement for Medicare beneficiaries, controlled new benefit costs and utilization, financed the new benefits out of current funding streams, and integrated the acute and long-term care service systems. Besides serving as an apparently feasible model for HMOs—costs are reasonable for both government and beneficiaries—the SHMO experience might well serve to guide broader long-term care reforms.

In this paper, we present an overview of the SHMO demonstration, summarize its outcomes and advantages, and describe the problems and shortcomings we have encountered. The paper and supporting data deal primarily with feasibility and costs, since the comparative evaluation of patient outcomes and cost-effectiveness will not be completed until late 1991.

BACKGROUND ON THE SOCIAL HMO

The SHMO concept was first proposed to the Health Care Financing Administration (HCFA) 10 years ago. The idea was a confluence of then-emerging streams of research and demonstrations on reforming the financing and delivery of health care and long-term care. From one direction came the concept of risk reimbursement to HMOs for Medicare beneficiaries (Iglehart, 1987). From the other came the concept of expanding long-term care benefits under Medicare, Medicaid, and private financing (Blumenthal et al., 1986; Kane & Kane, 1985; Ruchlin, Morris, & Eggert, 1982; Somers, 1987).

Since then, Medicare HMOs have been tested and implemented in the 1982 Tax Equity and Financial Responsibility Act (TEFRA) program. More than a million Medicare beneficiaries are now in HMOs, and at least one TEFRA HMO is now available to more than half of the Medicare population (*Medicine & Health*, 1988; Simone, Lichtenstein, & Adams-Watson, 1988). Finding ways to expand long-term care coverage has presented special difficulties because, unlike coverage under the TEFRA program, most long-term care proposals have required new financing in a time of retrenchment in health and social service budgets.

While overcoming many of these difficulties, the SHMO sites have not lacked for problems, including marketing headaches and

initial losses. Benefits still exclude long-term nursing home stays, and the results of the outside evaluation of impact on hospital and nursing home utilization and Medicaid spend-down are not yet available. HCFA's evaluation of patient outcomes, utilization, and costs in the SHMO versus those in a fee-for-service comparison group will likely be released late in 1991. This evaluation will answer important questions, but we need not wait for the answers to make judgments on the feasibility and costs of adding new long-term care benefits through the SHMO model. If sponsors can attract members, and finance and manage new benefits from new funding streams, the model does not need to promise institutional or Medicaid offsets to survive.

The data we present in this paper are from two of several data sets maintained by the SHMO Consortium, a cooperative research and policy analysis effort of the four demonstration sites and Brandeis University. One data source is the Management Data Set, which contains monthly membership, case mix, utilization, and cost data for both acute and long-term care services. (Data have been gathered by each site according to standard specifications, and compiled centrally.) The other is the Finance Data Set, which is based on the sites' quarterly cost-reporting to HCFA.

FINDINGS BASED ON THE SHMO MODEL

Surviving in Competitive Health Care Markets

In times of increasing competition and tightening reimbursement, each of the four sites that began planning for the demonstration in 1982 was nevertheless able to begin operations in 1985, go at full risk in 1987, and continue through the present. The survival of four different sponsors shows the SHMO to be a flexible organizational model, but some approaches seem easier to implement. As shown in the top portion of Table 1, the Seniors Plus and Kaiser Permanente sites are sponsored by established HMOs, while Elderplan and SCAN Health Plan are new HMOs initiated by long-term care organizations. Thus, at the former two sites, the SHMO is essentially a new benefit program for the existing HMO, while at the latter two the new HMO and SHMO are one in the same. Being able to start

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Table 1

SHMO SITE CHARACTERISTICS: 1988

	SENIORS PLUS	SCAN HEALTH PLAN	KAISER PERMANENTE	ELDERPLAN
Location	Minneapolis, MN	Long Beach, CA	Portland, OR	Brooklyn, NY
Type of sponsor	Comprehensive LTC organi- zation & HMO	Case management agency	HMO	Comprehensive LTC organi- zation
Other major organizations	none	Hospital & IPA medical group	none	Multi-specialty medical groups
Type of SHMO	New benefit program	Own HMO	New benefit program	Own HMO
Total members (12/88)	3031	3041	5005	5015
Member premium (/mo)	\$29.95	\$24.95	\$57.00	\$29.89
Annual LTC limit (1)	\$7,200/yr	\$7,500/yr	\$12,000/yr	\$6,500/yr
Home care copay	20% of charges	\$7.50/visit	10% of charges	\$10/visit
Nursing home copay	20% of charges	20% of charges	10% of charges	20% of charges

(1) Benefits renew annually or monthly for community residents but not for long-term nursing home residents, except at Elderplan. Figures are gross benefits before copays. Benefit dollars may be spent on personal care, homemaker/chore, home health aide, medical transportation, emergency alarm, nursing, therapies, and custodial nursing home care as authorized by the health plan.

from an existing medical care and administrative base of an HMO is definitely the easier and less expensive path to organizing an SHMO (Leutz et al., 1988; Leutz et al., 1985).

Slow enrollment was initially a problem at three of the four sites, but all now have reached break-even membership levels (Leutz et al., 1990). At the end of 1988, more than 16,000 Medicare beneficiaries were enrolled. Members pay premiums ranging from \$25 to \$57 per month, comparable to local Medex supplements but somewhat higher than local HMO competition not offering long-term care benefits. These rates are also much more affordable than private long-term care insurance policies, which commonly run between \$75 to \$100 per month or more. Private insurance covers much more nursing home care than the SHMOs, but generally less home care, and of course, no Medicare acute supplement (VanGelder & Johnson, 1989). Generally, SHMOs have enrolled members who are similar to their communities' Medicare beneficiaries in terms of severe impairment, slightly sicker in terms of moderate impairment, and less on the extremes of either excellent or poor health (Greenberg et al., 1988; Harrington, Newcomer, & Friedlob, 1987).

No systematic analysis of the SHMO's marketing problems is available, but factors hurting enrollment seem to have included the following: higher prices than competing HMOs, the need of many enrollees to change physicians, misunderstanding by beneficiaries of the gaps in Medicare coverage, the short-term demonstration status of a long-term care program (initial waivers were for only 3.5 years), and increasing competition in the Medicare market. The problems were most acute at SCAN Health Plan and Elderplan, which had the additional barrier of being brand-new entities in their communities.

Defining a New Long-Term Care Entitlement for Medicare Beneficiaries

Medicare beneficiaries joining the SHMO acquire contractual rights to long-term care benefits that are analogous to their rights to Medicare benefits. That is, if they meet eligibility criteria, they are entitled to services up to the limits of the benefits, if clinically au-

thorized. As with organizational structure, the entitlement appears to be sufficiently robust to be manageable under alternative approaches to limits and eligibility.

The bottom portion of Table 1 shows definitions of expanded long-term care benefits by site. In addition to all Medicare benefits, prescription drugs, eyeglasses, and other ancillary benefits, between \$6,500 and \$12,000 of expanded long-term care benefits are available per year to members who qualify. The benefits are renewable annually for members who remain community residents, but benefits for permanent nursing home residents expire after relatively short stays. The large expenses and high risk of long-term nursing home costs could not be financed within current funding streams, so we decided to focus funds on ongoing community care plus front-end nursing home coverage.

The very limited provision of long-term nursing home coverage is a regrettable and substantial gap in financial protection, but filling gaps in Medicare home health and nursing home benefits has also proven to be important. The SHMO's long-term care benefit structure provides longer and more intensive post-acute care, ongoing monitoring and service for the medically complex and unstable, long-term in-home and community-based support for ADL (Activities of Daily Living) and IADL (Instrumental Activities of Daily Living) dependencies, and short-term nursing home stays for convalescence, respite, and other purposes. Although the SHMO sites are a ways from perfecting definitions and procedures for targeting patients with these needs, the front-end, community-oriented, long-term care benefits fill these gaps at a reasonable cost and give beneficiaries what they seem to want the most from the health and long-term care systems: the chance to stay at home with maximum independence for as long as possible.

Expanded care benefits are controlled by an independent care management unit staffed by a mix of nurses and social workers. They assess members and authorize care plans that can include personal care, homemaking, day health center, transportation, electronic monitoring, short-term nursing home care, and more. Most sites manage the long-term care benefit through a monthly limit (one twelfth the annual limit). Co-payments vary in level and structure. Benefit structures are detailed elsewhere (Leutz et al., 1988).

Controlling Utilization and Costs of Expanded Long-Term Care Benefits

One of the major fears of potential insurers for long-term care — both public and private — has been that community benefits could not be controlled. Our experience does not bear out this fear, and we have gained insight into factors for managing utilization levels. Aside from dollar limits on benefits, the SHMO's primary control over utilization of long-term care services is to tie eligibility to need for nursing home care. Table 2 shows that at SCAN Health Plan, Kaiser Permanente, and Elderplan members must be nursing home certifiable (NHC) by state preadmission requirements to be eligible for long-term care. Seniors Plus serves NHCs as well as those judged at risk of becoming certifiable. (SCAN Health Plan had more liberal eligibility criteria prior to late 1987 when it narrowed eligibility to reduce costs.)

Table 2

ELIGIBILITY AND UTILIZATION OF LTC BENEFITS: 1988

	SENIORS PLUS	SCAN HEALTH PLAN	KAISER PERMANENTE	ELDERPLAN
Expanded care eligibility criteria (1)	NHC or at risk of NHC	NHC	NHC	NHC
Percent NHC (2)	7.7%	6.9%	9.3%	4.5%
Percent with care plans (2)	8.6%	6.9%	5.4%	4.2%

(1) NHC stands for nursing home certifiable by state preadmission screening criteria.

(2) Mean monthly average

Source: SHMO Consortium Management Data Set

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Table 2 shows that between 4.5% and 9.3% of members were nursing-home certifiable in 1988. The proportions of this group have risen over time at Kaiser Permanente, but proportions at the other three sites have remained stable. Explanation for the Kaiser Permanente rise include the aging of the large, initial membership and increasingly adverse selection under unrestricted open enrollment. Four percent of the 4,144 members who enrolled in Kaiser Permanente between March 1985 and May 1986 were nursing-home certifiable at enrollment, while 6.5% of the 2,530 who enrolled from June 1986 to December 1988 were in this category at enrollment. By December 1988, however, the overall rate was 10.6% of the membership, indicating that substantial numbers of members became certifiable after enrollment. The other three sites have queued some new applicants who were severely disabled to maintain prevalence of ADL disability at community rates. Nursing-home-certifiable rates at these three sites have remained within a point of the figures in Table 2 for three years.

The proportion of the total members with an expanded long-term care plan (i.e., actually receiving expanded long-term care services) is a function of the eligibility definition and the proportion of members who are nursing-home certifiable. Not surprisingly, the three sites with such eligibility do not provide long-term care to more than the number of those in this category, usually because informal caregivers meet all needs of those in the community but also sometimes because services are refused. This has also been the case in prior long-term care demonstrations (Montgomery & Borgotta, 1989; Weissert, Wan, & Livieratos, 1980). At Seniors Plus, which services NHCs as well as those at risk of becoming certifiable, there were active care plans for about 12% more than the number of NHCs. When SCAN Health Plan changed to nursing-home certifiable targeting, its proportion with care plans dropped from 13.5% in December 1987 to 6.9% in December 1988.

Table 3 shows the per-member per-month (PMPM) cost of expanded long-term care services and care management at each site for 1986 through 1988. Despite substantial differences in targeting and benefit caps, expanded long-term care service and care management costs per capita are remarkably similar across sites. In 1988, service costs ranged between \$27 and \$30 PMPM, case management costs ranged between \$7 and \$12 PMPM, and overall costs

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Table 3

SERVICE AND MANAGEMENT COSTS FOR EXPANDED CARE: 1986-1988

	SENIORS PLUS	SCAN HEALTH PLAN	KAISER PERMANENTE	ELDERPLAN
Service costs (PMPM)				
1986	\$29	\$26	\$21	\$32
1987	\$25	\$29	\$25	\$22
1988	\$27	\$27	\$30	\$29
Management costs (PMPM)				
1986	\$9	\$13	\$4	\$10
1987	\$8	\$16	\$7	\$7
1988	\$7	\$12	\$7	\$7
Totals (PMPM)				
1986	\$38	\$39	\$25	\$42
1987	\$33	\$45	\$32	\$29
1988	\$34	\$39	\$37	\$36

Kaiser, Seniors Plus, and Elderplan benefit costs are gross before copays. SCAN costs are net.

Source: SHMO Consortium Finance Data Set

ranged between \$34 and \$39 PMPM. The data also show that sites have been able to control costs over time in both services and care management. These costs have been stable or decreased at SCAN Health Plan, Seniors Plus, and Elderplan, partly because of queuing to hold case mix constant and modest benefit restructuring (e.g., the

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narrowing of targeting to those nursing-home certifiable at SCAN Health Plan and a reduction in the number of nursing home days covered at Seniors Plus). Kaiser Permanente's service costs have increased as its case mix has become more disabled, but care management costs have been held stable.

Complementing Medicare Home Health and SNF Benefits

SHMOs integrate the payment and management of all home care and nursing home services whether these services meet Medicare or long-term care criteria. Integration provides the incentives and the means to develop the least costly service package that is appropriate to meet patient needs. Although sites have integrated Medicare and long-term care services in practice, they maintain separate authorization and payment records in order to assure on the one hand that members receive full benefits for services meeting Medicare criteria, and on the other hand that they manage long-term care services within the benefit limit.

These payment records are the basis of the data in Table 4, which shows 1988 costs and utilization per member for nursing home services and home- and community-based (H&CB) services by site for Medicare and expanded long-term care services. Hospital utilization is also shown. Looking first at nursing home services, data show that utilization of the expanded long-term care benefits is greater than that of Medicare skilled nursing facilities (SNFs) at all sites and at least double the rate at three sites. Because Medicare SNF days cost more, however, the relative costs of the two benefits scale differently, with the Medicare SNF costs at SCAN Health Plan and Elderplan actually exceeding the costs for long-term care days.

Evidence suggests that the extra nursing home coverage is a useful complement to community services. A Kaiser Permanente study of 1987 nursing home utilization under expanded care found that more than 60% of the stays were classified as part of helping members remain in the community. Overall, the goal of nearly 41% of authorizations was extended convalescence; 28% were associated with a general decline in condition; 10% each were to accommodate medical flareups and terminal illness; and the remaining 11% were

*Leutz et al.***Table 4: SELECTED 1988 SERVICE COSTS AND UTILIZATION:
MEDICARE VERSUS EXPANDED LTC (\$PMPM)**

	SENIORS PLUS	SCAN HEALTH PLAN	KAISER PERMANENTE	ELDERPLAN
1. NURSING HOME				
Days/1000/year				
Medicare	473	1083	859	995
Expanded LTC	1377	2083	2341	1184
Cost/member/month				
Medicare	\$3.14	\$20.43	\$6.08	\$14.03
Expanded LTC	\$8.10	\$13.12	\$13.49	\$11.75
2. HOME & COMMUNITY-BASED				
Skilled visits/1000/yr				
Medicare	1376	242	1156	1988
Expanded LTC	370	31	84	0
Unskilled hours/1000/year				
Medicare	494	0	373	6178
Expanded LTC	9658	11603	14290	33581
H&CB Cost/member/month				
Medicare	\$4.49	\$3.39	\$17.98	\$11.31
Expanded LTC	\$18.57	\$14.03	\$16.81	\$17.01
3. TOTAL NH & H&CB COST/MEMBER/MONTH				
Medicare	\$7.62	\$23.82	\$24.06	\$25.34
Expanded care	\$26.67	\$27.15	\$30.30	\$28.76
4. ACUTE HOSPITAL				
Days/1000/year	1889	2079	1889*	1872

* January-June only, since July-September data are unavailable due to work stoppage.

usually associated with caregiver issues such as respite, caregiver crisis, or the lack of support altogether (Greenlick et al., 1988).

Utilization data for home- and community-based care are displayed in Section 2 of Table 4 for both skilled visits (including nursing and therapies) and unskilled hours (including home health aides, personal care workers, and homemakers). Not surprisingly, skilled visits predominate in Medicare utilization at all sites, and unskilled hours predominate under the long-term care benefit. At Seniors Plus and SCAN Health Plan, costs for home- and community-based care under long-term care are more than four times the costs under Medicare home health, while at Kaiser Permanente and Elderplan costs under the two benefits are more similar. Only at Kaiser Permanente do Medicare home-health costs exceed expanded-care costs in the community.

It is interesting to note that all sites except Elderplan find it appropriate to cover at least some skilled in-home services beyond Medicare coverage. Although no systematic study of the reasons for additional skilled utilization has been conducted, case studies found authorizations for additional therapies, nursing supervision, and monitoring of unstable conditions (Abrahams, Capitman, Leutz, & Macko, 1989). Kaiser Permanente data show that nearly two thirds of 494 referrals of current members to the long-term care unit in 1988 came from traditional Medicare settings, including 30% from hospital discharge, 19% from home health, 8% from outpatient department social workers, 7% from skilled nursing facilities, and 2% from physicians. This indicates the overlap of the acute and long-term care patient populations, and thus the importance of integrating long-term care programs with the medical care system.

Section 3 of Table 4 displays the overall costs for Medicare and expanded care benefits in nursing homes and the community. Expanded long-term care costs range between \$27 and \$30 PMPM across the sites (as noted in Table 3), slightly above Medicare costs of between \$24 and \$25 PMPM at three of the four sites, and far above Seniors Plus Medicare costs of \$8 PMPM. The substantial Medicare difference at Seniors Plus, as well as the large cross-site differences in Medicare nursing home and home-health costs, indicates that it may be no more difficult to define and manage a new entitlement for long-term care than it has been to consistently define

and manage the uniform Medicare entitlement for home-health and nursing-home services.

Creating Insurance for New Long-Term Care from Current Funding Streams

SHMOs are financed by pooling Medicare and member premiums. The representative population and prepaid financing allow SHMOs to establish insurance risk pools to pay for the expanded chronic-care benefits. Medicare pays monthly rates set at 100% of what would have been spent on the members in the local fee-for-service system, as calculated in a modified version of HFCA's adjusted average per capita costs (AAPCC) formula. Regular Medicare HMOs receive 95% of this formula. To compensate for the higher medical costs of community residents who are nursing home certifiable, the formula has been modified to pay SHMOs the higher institutional rate for NHCs (about double the overall average in the AAPCC), while paying slightly less for nondisabled community residents.

Because the SHMO is a prepaid system that pools member and third-party premiums to pay for all services, it is not possible to say exactly how long-term care or other particular parts of the benefit package are financed. The clearest source is the additional 5% of AAPCC beyond what regular HMOs receive. The 5% amounted to between \$11 and \$17 PMPM in 1988, which paid for just under a third to nearly one half of expanded long-term care costs. A second source is member premiums, which covered between 64% and 158% of expanded long-term care costs. Thus, at all sites, the combination of the extra 5% of the AAPCC and member premiums is more than enough to pay for expanded care. A third source is acute-care savings coming from the efficient use of hospitals. Section 4 of Table 4 shows that all four sites have similarly low hospital utilization rates. Savings compared to fee-for-service hospital costs are used to pay for both long-term care and ancillary medical services.

Until 1988, three of the four sites experienced losses, primarily because of high administrative and marketing costs associated with slower than anticipated enrollment (Leutz et al., 1990). The losses

were highest at Elderplan and SCAN Health Plan, which did not have the built-in economies of scale of the existing HMOs at Kaiser Permanente and Group Health Incorporated (the Seniors Plus HMO sponsor). Although it may be argued that the SHMO stretches the limits of what can be financed and sold within the HMO model, these are financing and marketing issues, not arguments against the feasibility of designing an affordable and controllable long-term care entitlement. The four sites all set aside similar long-term care budgets and met them, which is testimony to the fact that community long-term care benefits can be accurately defined and managed. This finding stands independent of early bottom-line losses at some sites.

DISCUSSION

In the wake of the debacle of the Medicare Catastrophic Coverage Act, the success of the SHMO model presents policymakers with an opportunity to give millions of beneficiaries access to virtually all of the Act's acute-care protections plus significant new benefits for community-based long-term care. At the same time, the SHMO experience points to a viable path for HMOs to regain their position as the most comprehensive health care option in the marketplace. A few changes in TEFRA could make it feasible and attractive for HMOs to offer an SHMO benefit, with no additional costs to Medicare. The conditions to make it happen could be modeled on the current SHMO waivers concerning minimum long-term care benefits, targeting criteria, payment methodology, and case-mix controls.

Looking beyond the HMO setting, the SHMO sites have tested key components for broader long-term care reforms. We have shown that costs are linked to case mix, targeting, and benefit definitions, and that each of these can be controlled or compensated for in reimbursement and regulation. We have also shown that it is important and possible to establish close communications and coordination of care with physicians and hospital discharge planners, home health nurses, and nursing homes when there is a clear and professionally managed source for continuing care. Because the

SHMOs have enrolled memberships similar to the Medicare population, service utilization patterns of these organizations and the costs involved can guide estimates of utilization and costs of a national program. We can only attest to the feasibility in managed-care settings, but the findings suggest that tests in fee-for-service settings are warranted.

Although the SHMO model has proven feasible and affordable, its components could be improved with further research and development. Alternative eligibility definitions should be analyzed to improve understanding of what types of patients are defined in and out of coverage with particular criteria. Care management norms should be developed that provide guidelines for expected outcomes, service mix, and duration and intensity of care for defined patient subgroups. Standards for assessing and assuring quality, especially in home care, are needed. Systems for case-mix reimbursement and contracting for management of expanded long-term care should be devised and tested. Better estimates are needed for the changes in long-term care costs produced by an aging membership. These are the priorities for both the SHMO and for the broader health and long-term care systems.

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Chairman STARK. Do any of you gentlemen, or your organizations feel that there is a positive necessity to have the mandatory alliances that are outlined in the President's plan? Do they do anything for you negatively or positively or could the system operate just as well without them? Mr. Thorpe.

Mr. THORPE. My sense is that managed care—

Chairman STARK. That isn't what I said. I said the mandatory alliance. Is that something that you feel is useful to your group?

Mr. THORPE. In my view that is not particularly useful because I believe managed care is unfolding with or without governmental intervention.

Chairman STARK. By unfolding, you mean developing like a flower?

Mr. THORPE. It is developing and unfolding on its own through market forces.

Chairman STARK. So you think it will do quite well with letting nature take its course?

Mr. WILLING. I would agree with you, Mr. Chairman, it would appear to be neutral as far as we are concerned. In the basic benefit package, which doesn't have much to do with the alliance, the 100-day alternative to a stay in a hospital, you could do that with or without the alliance. It has nothing to do the alliance.

Chairman STARK. I am trying to figure out because they describe the alliance like just another slice of salami in the sandwich, you pull that out and you still have a salami sandwich. And the other parts of it still seem to function. Mr. Rodgers.

Mr. RODGERS. I think our members are unique insofar as they are recipients of Federal and private health dollars, but they are also employers, and, as such, one of the complaints that we are hearing from many of our members is the tremendous increases in health premiums that they face year after year. So from the standpoint that an alliance can allow some of these smaller entities to pool some of their purchasing—

Chairman STARK. I wasn't suggesting that things like CALPERS or a variety of employer groups couldn't exist, but you don't need this sort of 300 pages of alliance definition to do it. I am just trying to figure out as I go through this bill—I mean, there is nothing to prevent your folks from getting together now if they are in California, for example, and forming a purchasing group as CALPERS has done. And that ought to satisfy their needs.

Mr. RODGERS. It is just that it appears that the alliances these tended to formalize purchasing cooperatives and make it easy for the smaller employer entities to access the health insurance market within a larger pool. So, I think that we probably would be neutral, but we would support the development of some type of co-op so that people could access it that way.

Chairman STARK. Would you support them therefore being available, but not mandatory? In other words, to be able to facilitate them and if we have antitrust problems or whatever else they have done, and as we have in California, they could organize one? Do you have any trouble with that?

Mr. RODGERS. We haven't given it a lot of thought, but I don't think we would have any problem with it.

Chairman STARK. We thank the panel a lot. And I am sure we will be seeing a lot of you in the months ahead. The committee is adjourned.

[Whereupon, at 1:40 p.m., the hearing adjourned, to reconvene on November 4, 1993.]

[Submissions for the record follow:]

The Illinois Association of Community Care Program Homecare Providers
An Association of Community Care Providers

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Committee on Ways and Means
 Subcommittee on Health
 Health Care Reform

February 4, 1994

I am Jeanne Tippet representing the Illinois Association of Community Care Program Homecare Providers. We represent the providers funded by the Illinois Department on Aging's Community Care Program servicing approximately 26,000 older persons monthly in their homes via Homemaking services.

When we hear how will Health Care Reform impact Illinois we can currently only address the intent. We will have a better response and understanding when we know exactly what the package will be. We certainly appreciate the difficulty for all in implementing such a gargantuan change.

What we strongly want to share with you is the importance of the section re long term care and community based services. Without that component, as they say, we will be in a world of hurt. Without prevention and delay of institutional care for all, especially for the older person, any other system will be much more costly. In fact if this type of approach does not remain in Health Care Reform, we would suggest dollars be developed right now to start building costly institutions as you will eliminate a central core of care. Without long term care and community based services one must either be able to care for oneself or be placed in an institution for care.

The homemaking services via the Illinois Department on Aging's Community Care Program is a viable base to establish a program of long term care and community based services. It addresses service at a reduced cost, employment issues, self esteem for both homemaker worker and client, pride, self satisfaction, family values and delay or prevention of more costly institutionalization. Long term care and community based services cuts across all age lines but we as the Association address the needs of the older person and those employed to service their needs.

As we are all aware our population is aging at a greater rate than anytime in history. The number of older persons in Illinois has grown by 8.66%, the 75 and over population by 22.83% while the total number of Illinois citizens increased by only .04%. Currently the services provided to 26,000 older persons via the Community Care Program providers creates an employment base of close to 15,000 employees. Therefore, this service impacts several facets. A less costly service is provided, a major workforce is maintained, thus reducing cost by providing inhome services and employing people.

Unfortunately, this service has continually been under funded. The rate reimbursement has not kept pace with cost and the homemaker worker basically receives minimum wage with few or no benefit package. Even with that downside this lower cost type of service can not be excluded. It should be the base end built upon for a more comprehensive approach to non medical care support services. This will reduce costs and meet the needs of those who do not need costly skilled care. When services were cut due to budget constraints we could see an increase in hospitalizations and nursing home placements. This creates higher cost, concern and cost on family caregivers, as well as clients loss of choice on how to live their remaining years. It also affected homemaker workers as they lost hours and wages which probably put them back on Public Aid roles. These facts are addressed at a minimum in this presentation but do have a strong impact and need for long term care and community based services to remain in Health Care Reform.

In addition to addressing and maintaining the long term care and community based services as a preventive to more costly services we must at some point review our Public Aid system. Our mindset must change from one of institutionalization to inhome care. This will realign dollars within Medicaid to consider inhome care as an alternative to institutional placement, not the other way around.

We understand Health Care Reform cost can not stand alone. We further understand it must keep pace with the changing demographics, employment issues and who is to pay for care. The Association's concern is that with the current low reimbursement rate how can we as employers meet the cost of adding insurance provision. This could eliminate an entire industry. We assure you that we feel strongly that all peoples should have access to health care but the cost cannot be on the employers only. It must be a shared expense.

The Association strongly suggests that:

LONG TERM CARE AND COMMUNITY BASED SERVICES MUST REMAIN IN HEALTH CARE REFORM

DO NOT develop the program in such a restrictive manner that preventive and less costly in home services are deleted.

DO NOT put the cost on the backs of employers.

DO NOT gut the current system, only address what is broken in the system.

Make certain insurance is portable and preexisting conditions do not keep someone from receiving or continuing insurance. Make insurance responsible for their own inflated expenses. DO NOT make them the overseer of a program whereby they have been part of the problem.

BUILD from bases that are already established. Look at what is good in our Health Care System and what needs to be changed.

DO NOT develop a whole new system that has not been tested and no one knows if it will work or how much it will cost. Create demonstration projects prior to full implementation to work out major problems before costly errors are made, both human and monetarily.

Government does not need an expanded role in Health Care. DO NOT create more layers of bureaucracy. This only increases costs and does not address the problem of health care. The consumer remains the important factor. Consumers must continue to have recourse in their care and not be governed by unknowing government staff.

YES, all people should have the right of health care. But the system must be one that does not diminish health care where no one has adequate care. The dollars should not be put into Alliances, Health Care Boards, etc. it should be put into HEALTH CARE.

Thank you for the opportunity to address this issue. If we can be of any assistance by gathering information or statistics do not hesitate to call on us.

TESTIMONY FOR THE NATIONAL ASSOCIATION FOR THE SUPPORT OF LONG TERM CARE

Mr. Chairman, the National Association for the Support of Long Term Care is a broad based alliance of suppliers and providers of professional medical services and products. Over 150 companies are active NASL members. Through our structure of six working coalitions (rehabilitation, wound care, medical product and supplies, portable X-ray, clinical laboratory, and pharmacy services), we are able to provide an assessment of issues which would affect the ancillary and support services offered to patients in nursing facilities.

We appreciate the opportunity to provide testimony on President Clinton's legislation entitled "The Health Security Act of 1993." We applaud the President and Mrs. Clinton's leadership in offering Congress legislative solutions to ensure all Americans have access to affordable health care services. We commend President Clinton's leadership in defining six points for reform: security, simplicity, savings, quality, choice, and responsibility. As an association, we are also committed to these key principles, however, we believe that some areas for reform are not adequately addressed and we offer constructive input in reforming the plan, especially for those services provided in the nursing home setting.

The Changing Setting for Skilled Nursing Care

Over the past decade, nursing facilities have transformed into centers for subacute medical services. Several dynamics have propelled this transformation: higher patient acuity as patients are transferred out of hospitals at a quicker pace; changing care settings which allow patients to receive services in the least restrictive settings based on patient need, quality, and safety considerations; and regulatory mandates as included in OBRA '87 which requires that nursing homes help residents achieve "the highest practicable level of functioning."

Patient needs, mandated changes and market opportunities have placed tremendous demands on facilities to upgrade professional medical services. Nursing facilities have strengthened physician relationships, increased the utilization of specialty medical services and supplies and expanded specialty programs. They have turned to the members of NASL to request an expansion of our support services and programs to meet their residents' needs.

President Clinton's Health Security Act of 1993

We remain concerned about various issues which need to be addressed in greater depth: 1) opposition to medicare cuts to finance health care reform; 2) leveling the playing field across all settings; 2) enhancing the long-term care public/private partnership; 3) committing resources only with adequate financing; and 4) the residual Medicaid long-term care funding.

Proposed Medicare Cuts

We oppose using Medicare cuts as a funding basis for health care reform. The proposed \$124 billion in Medicare cost increase reductions will erode the quality of care provided to elderly and disabled citizens, even those in need of long term care. As a nation, we cannot afford to provide lower quality care to the many in order to expand that care to the few.

Leveling the playing field for all providers

While the focus of the legislation is to ensure all Americans have access to adequate health care, NASL believes no provider categories should be excluded from the market place. Rules may be necessary to prevent such exclusions. Patients receive appropriate services in hospitals, nursing homes, assisted living facilities, or at home dependent on the availability of services and acuity of the patients' needs. Health care reform must give providers, suppliers and patients the assurance that no artificial barriers will trap patients in one setting or another. Judgments must be made on the appropriate use of all existing medical services, and we must ensure access to professional services in all settings.

Public/Private Partnership

Long term health care must be a part of any truly comprehensive effort at health care reform. Title II of the President's plan should stimulate meaningful debate. Given limited government resources to finance long term care for every American, we cannot rely on a system that is publicly financed. We support a system that urges Americans with the financial means to plan and pay for long term care as part of a public/private partnership for long term care services. We believe the American Health Care Association's proposal has advanced a positive approach for long term care services:

- Provide appropriate access to a full continuum of long term care services,
- Ensure that all Americans have the means to meet the cost of long term care,
- Move families away from dependence on government welfare programs for long term care financing, and
- Address the nation's long term care needs in a fiscally responsible way.

The public/private plan should 1) rely on case management for the most appropriate placement for services; 2) strengthen enforcement of Congress' recently passed Budget Reconciliation Act asset transfer provisions and; 3) create value in the long term care private insurance market by setting standards which safeguard purchasers of long term care insurance.

Oppose Artificial Price Caps and Global Budgets

While there is a desire to ensure access to affordable health care, NASL is concerned about the development of unrealistic expectations. By the creation of global caps which set funding limits on health care services, medically necessary services may be rationed. When people are in most need of care, they may find themselves out of money and exceeding some artificial government cap. We oppose capping the health care system and urge Congress to avoid such price controls that only stifle innovation and erode the quality of health care services.

NASL believes that important alternatives are necessary to controlling costs. First, we must develop a continuum of care management which ensures that patients receive appropriate services in appropriate settings. Merely setting artificial time-frames or dollar amounts for care ensures rationing. Second, we believe that health care professionals must be allowed to provide services they are trained and licensed to provide. Finally, we believe costs can be reduced by ensuring patients complete their rehabilitation to improve their functional capacity and prevent further deterioration. We are most concerned that without adequate reimbursement for supporting ancillary services and appropriate follow through, the system will become more, not less, expensive.

Adequate State Financing

As President Clinton's plan creates a new capped entitlement for home and community based services, NASL is very concerned about the impact of this program on States' ability to adequately finance long-term care services under Medicaid. As there will be driving forces to finance both institutional and home based services, quality in both may be eroded. Again, we believe that patients needing long term care should get services where the care may be most appropriately provided. That will, in some instances, be institutional, in others home based. We believe that there should not be categorical exclusion based on place of service and believe that the creation of new entitlements for services at home may create unrealistic expectations or unanticipated expense. A phenomenon known as "the woodwork effect" will likely develop. In the woodwork effect, informal caregiving (currently unreimbursed as health care) erodes as people become eligible for paid home care. Availability of such care will automatically increase demand. Such demand for services in light of existing state budget constraints will likely force States to either increase taxes to pay for the additional demand or reduce provider payments, thereby reducing the quality of services. We urge you to proceed cautiously in a fiscally sound way to ensure that we strengthen, not erode, an important public/private partnership in providing long term care benefits to Americans.

Conclusion

The key to ensuring Americans' access to quality services is to encourage competition on fair terms with adequate reimbursement. We fear reforms may not let smaller providers compete on the basis of access and quality. We urge you to consider that if reforms are not carefully thought through, there may be a bias against the small provider who serves patients in nursing homes, in rural areas, and in places where large, national providers rarely serve.

We are ready to work with members of Congress in developing meaningful reforms. We offer our expertise in defining the role of the ancillary provider in the evolving program for providing health care services. We remain eager to provide additional input on the reform plan and you may look forward to our continued communication and cooperation.

PRESIDENT'S HEALTH CARE REFORM PROPOSALS: IMPACT ON THE ECONOMY AND JOBS

THURSDAY, NOVEMBER 4, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 11:07 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

Chairman STARK. Good morning. Today, the Subcommittee on Health continues its hearings on the administration's health care reform proposal.

The issue under consideration is the probable impact of health care reform on the economy and on jobs, with additional testimony providing the views of large and small employers.

Before proceeding, I would like to suggest a couple of points that Members I hope will keep in mind as we consider these issues.

First, any health reform plan that both fairly finances universal coverage and controls health care costs will have significant effects on our economy. You cannot rearrange one-seventh of the economy without some impact on the remaining segments.

It is also true that doing nothing will have a serious economic impact. Profits and wages will continue to be depressed by the rising health care costs. Some businesses will try to avoid these costs by shifting them on to others or moving to Mexico.

Some insurance companies will continue to respond to the perverse incentives that reward those who discriminate against the very people who need their product the most. And some practitioners and providers will continue to use our health care financing system as an open checkbook for their personal use.

So while it is true that health care reform will have many significant effects, I hope that we can consider the costs and benefits of the reform in the context of the third alternative which is business as usual.

Some of the economic changes arising from the reform will have positive effects. One example, the effects of slowing inflation on health care costs. In a \$900 billion system growing at over 10 percent, a 1 percent annual reduction in growth, not an absolute reduction but just a reduction in growth, frees up tens of billions of dollars by the turn of century.

Many of these savings would be in the private sector, and unfortunately could not be used to increase private sector wages and investments by law. They might be out of the goodness of the corporate heart, but the Chair is rather skeptical about that as a means for increasing wages and investment.

Finally, I understand that many people are worried about the impact of health care reform on jobs. I do not share this concern. In the long run, it will stimulate the economy and create more jobs. In the short run, I believe its impact is relatively minor, and might indeed be offset by an increase in jobs in the health care field. 85 percent of employees already have health insurance and pay for it through a combination of employer contributions and their own money.

In the short run, health care reform will have little financial effect on the large majority of workers, and no impact on the number of these types of jobs. Middle and higher income workers without insurance may see some adjustment over time within their total compensation package, that is, shifts from wages to benefits, but these workers also would probably not see any real effect on their ability to find work.

If there is a significant impact, I think we could all agree that it would be on workers and jobs employed at the minimum wage and in the part-time setting. Given the subsidies provided in the Clinton plan, the employer contribution for a worker in a small firm could be as little as 20 cents an hour if the firm has very low average wages, at or below \$12,000, and this would be an equivalent of a 5 percent increase in the minimum wage.

Over the past 20 years the minimum wage has been increased 9 times. Each increase was more than the 5 percent implied under the health care reform and no one has shown any data that suggested that any of these minimum wage increases that has more than an infinitesimal, temporary impact on employment and that was principally teenage jobs for under the age of 18.

In fact some recent studies have even suggested that there was an increase in some types of employment. As you can gather, I am a skeptic on this issue. I don't believe that the Clinton proposal or any other proposal that is fairly financed would have any major impact on the availability of jobs.

So, with my usual open, ambivalent approach to these problems, I would be happy to recognize my ranking member to agree with my opening remarks.

Mr. THOMAS. Mr. Chairman, we have been told by the First Lady and others that the numbers have been scrubbed. When I am finished, we can evaluate whether I agree with you or not.

The numbers are scrubbed. No one can argue with the numbers. The numbers are accurate. We need to focus on the numbers and deal with the numbers in the bill and those primarily focus on cost redistribution. There are other numbers that I think are just as important in terms of the people impacted and whether or not they have employment. I am pleased to say that in front of us is the Honorable Laura D'Andrea Tyson, Chairman of the Council of Economic Advisors, so that we can get those numbers that have not yet been presented in terms of this plan.

I am sure they have been just as carefully scrubbed. I don't think it serves any useful purpose to talk about more or less, some or better, minor or maybe, if or but, when we are dealing with the economic impact of this plan when the other numbers seem so clean and so scrubbed and so unchallengeable.

If we are able to pin those numbers down, given the exigencies of having to pin those numbers down, then I assume as much diligence has been used in pinning the economic numbers down. If we are to look at the mother of all entitlements and move forward, we need to know. More, less, some, better, minor, maybe, if, or but, is not good enough, so I look forward to the testimony.

Chairman STARK. Are there other Members who wish to make a statement? If not, it is my privilege to welcome the Honorable Laura D'Andrea Tyson, the Chairman of the President's Council of Economic Advisors by way of University of California at Berkeley.

Before you proceed, I would like to remind my colleagues that you are not the Director of OMB or the Secretary of the Treasury or the head of CBO. And there are many important questions about the President's plan that may not fall to your department to answer.

We will have full committee hearings on the detailed financing, and they have been scheduled the week of November 15th. It is my understanding that Secretary Bentsen and other representatives from the administration will be here to respond to questions regarding specific financing issues.

Mr. Tyson is, on the other hand, the President's chief economic adviser. And thus she is the ideal person to address the issues of today's hearing; the impact of President Clinton's plan on the overall economy and jobs. Mr. Tyson, this is normally a question that my distinguished ranking member would ask, but in your academic background, did you have courses in spatial relations?

Ms. TYSON. Geometry is the only thing.

Chairman STARK. Geometry, that is all? Those of us who studied engineering have a lot of spatial relations and I wanted to ask you a question. Can you see me?

Ms. TYSON. Yes.

Chairman STARK. Now, because there is only one difference, do you recognize now that you are at the Ways and Means Subcommittee on Health and not the Energy Subcommittee on Health?

Ms. TYSON. I do recognize that.

Chairman STARK. That is the only real difference. She called Henry Waxman and asked what time she was to testify before his committee, and I wanted to say there is no real difference. They are both excellent committees and Mr. Bliley speaks differently from Mr. Thomas.

As for all of the witnesses, your prepared remarks will be in the record in their entirety, and would you just summarize your statement or expand on it or enlighten us in any manner that you are comfortable.

Welcome to the committee.

**STATEMENT OF HON. LAURA D'ANDREA TYSON, PH.D., CHAIR,
COUNCIL OF ECONOMIC ADVISERS**

Ms. TYSON. Thank you very much. And I am glad I found the right committee.

I will summarize what I have in my written statement and the summary will consist of first identifying what I consider to be the major problems in the current system and then summarizing what I believe to be the major economic effects of the plan that we have proposed.

In the current system there are five major reasons why we believe that urgent health care action is needed and these relate to the economy. The first is that the current system does not provide security to individuals: when people get sick, their cost of insurance can increase dramatically, or they can be dropped from coverage all together.

In some sense, what we are saying is that the insurance market is failing to do what an insurance market should do. Privately each insurer is operating in their own self-interest, but the net effect is a socially wasteful outcome. An outcome due to a market failure.

The second problem with the current system is that it distorts the employment decisions of individuals. This is a very important economic concern. First of all, because of the exclusion of preexisting conditions from the coverage of newly insured people, many people are locked into their current jobs. Studies suggest that up to 30 percent of employees report they feel locked into their jobs.

Some people might wish to start a small business or become self-employed, but the insurance rates are so high that they serve as a substantial disincentive for entrepreneurs. Other people are locked into welfare because leaving welfare means losing the Medicare coverage that they have.

We have a situation where the current system is preventing economic choices which would benefit the individual and benefit the economy.

The third problem with the current system is that the number of people who do not have access to insurance is large and increasing. We know that there are approximately 37 million people who do not have health insurance. We also know that three-fourths of these people are in working families.

It is very important for people to understand that even if you work in this society, you can easily be without insurance.

It is also important, and the Congress has focused on this a lot, as do health care experts, to note the cost shifting that goes on as a result of the fact that we have so many uninsured individuals. When the uninsured face catastrophic costs, the insured pick up the bill. The uninsured pay only 20 percent of the health care costs they incur while the privately insured pay 130 percent of their health care costs.

The uninsured receive more costly care than the insured because when they finally seek the care, they seek treatment in expensive emergency rooms rather than in a physician's office in the early stages of their illness. So we have both higher costs in the current system and we have cost shifting.

I am an international and comparative economist by training, so the fourth problem, which becomes evident when comparing health

care cost as a share of GDP in different countries and evaluating what has happened to them over time, is particularly compelling to me.

As I am sure you know, the United States spends a larger fraction of its GDP on health care than any of its major competitor nations. American consumers spend more on health care than fuel oil, electricity, natural gas, local transportation, and furniture and other household equipment combined. We are spending a tremendous amount on health care compared to other countries.

Now, the fifth problem is what I would call a market failure or excess supply or inefficiency problem. If you look at our health care system, there are inefficiencies and market failures because of insufficient competition.

Many consumers have little or no choice about the health insurance they receive and many providers have little or no incentive to control costs. Those are the two fundamental problems that lead to the lack of competition. As a result of lack of competition, we have a very costly system.

And even though we have a very costly system, on certain indicators of health care performance we don't do that well. Despite our massive commitment of resources to health care spending, the United States ranks 19 out of 26 countries in infant mortality and 18th in life expectancy. We lose \$80 million a year to fraud abuse and we spend over 5 percent of our total health care spending—conservatively \$45 billion in 1992—on administrative expenses and paperwork.

Many studies indicate that as many as one-third of common medical procedures may be unnecessary or inappropriate. An example of the lack of incentive is seen when you look at hospital prices around the country. When you have excess supply, you normally think that the price would fall if the market is working. If you look around the country where hospital beds are in excess supply, the price is usually increasing. And the HMO experience indicates that the cost in medical care can be cut 10 to 20 percent without compromising the quality of care.

The compelling picture here is the failure of incentives on both the consumer side—lack of choice and lack of information—and on the provider side—lack of incentive to control costs.

The reform that we have proposed will have many important economic effects which will address the problems that I have indicated.

First of all, it is very important to begin a discussion of the economic effects with the realization that many employers who currently offer health insurance would see their costs fall immediately as a result of our health security reform. This immediate reduction in cost would come from eliminating uncompensated care that would lower cost to businesses that currently provide care.

Also the reform would eliminate corporate-free riders. Now, employers that provide insurance oftentimes are providing insurance for the employee and the employee's spouse. Under reform, the employee's spouse, who is employed some place else, would get her insurance from her employer. So many companies would benefit right up front.

And then the economic question becomes how will the firms who benefit up front, how will they respond? What will they do with the benefits?

The second thing that I want to point out is over the longer run as the reform is phased in, business spending on the whole will decline. That is aggregate business spending on health insurance will be lower as a consequence of the reform, not higher as some people seem to suggest.

So we are going to have an improvement for many companies right up front and improvement for the business sector as the plan is gradually phased in. Our estimate, which we believe to be a relatively conservative estimate, is that by the end of this decade, aggregate business spending on mandatory services covered by the plan would fall by over \$10 billion.

The economic question is what will the business community do with the extra \$10 billion? They can actually do many things. They could hire more workers. They could provide higher wages or other benefits. They could invest more in plant equipment, education and training, research and development. They could increase dividends to their shareholders. They could lower prices. Any of these outcomes would have a beneficial effect on the economy.

So any possible way the business sector responds to the extra \$10 billion or more of savings which will be achieved as a result of reducing health care premiums over time will stimulate the economy. And I think it is very important to emphasize that.

Now, within the business community, I want to emphasize again the fact that small businesses will particularly benefit from the health plan that we propose. Again contrary to some press reports I have read which seem to suggest that small businesses will be worse off, small businesses will be particularly benefited by the health plan.

If you look at the current system, small businesses providing health insurance are really at a disadvantage. They pay much higher rates than large businesses. The premium costs are growing much more dramatically, sometimes two times the weight of the premium costs of the large firms.

There is a lot of uncertainty, the premium for a small firm can increase as much as 50 percent in a year. Small firms can face premiums that vary as much as 35 percent in price for the same benefits. So we believe that the small sector of this economy, the small business sector of this economy, will benefit greatly from having our health care plan in effect. They are likely to receive discounts that will make health care coverage very affordable.

Many small firms that are not currently providing health insurance report, in fact about two-thirds of them report, that they would like to provide health insurance, but they cannot afford it at the current exorbitant rates charged to the small business community.

They will be able to afford health insurance under our system with very generous price discounts offered to them.

The health security plan will also result in greater employment in the health care sector in the short run and a far more efficient health care sector in the long run. This is important to emphasize too.

This is not a plan which is going to reduce the number of people employed in the health care sector. It is going to increase the number of people employed in the health care sector. And then gradually as the sector becomes more efficient, it is going to slow down the rate of growth of the number of people employed in the health care sector, but it is not an absolute decline in employment in the health care sector.

It is actually initially an increase and then a slowing down of the rate of growth. That is important to emphasize. Over time, the health care sector will become more productive. That is, the market failures and inefficiencies I mentioned earlier should be addressed by better incentives, and greater productivity in the health care sector could benefit the entire economy.

Another important economic effect of course is reducing job lock and welfare lock. As I mentioned, the problem with the current system is that too many people have their options of employment limited by fear of losing coverage. In a system which provides universal coverage for all and security of insurance for all, people will be able to make the most productive employment decisions for themselves and their families.

Now, let me turn to an important economic issue of reform which has to do with the effect on the Federal budget deficit. We recognized early on in working on the budget plan that was passed in August that over the longer term it was important to design a health care reform package that helped address the outyear deficits.

We have designed one which we believe does help address the outyear deficits and without going into the details of the financing, which are in my written statement and we can discuss at length, our numbers show that over the period 1995 to the year 2000 we will raise \$390 billion from several sources of savings.

The projected spending by the Federal Government is \$332 billion leaving \$58 billion of deficit reduction between the year 1995 and the year 2000. We are making a contraction at the same time that we provide universal coverage and insurance security for all.

I want to emphasize that we do believe the financing numbers to be credible. They are based on a very careful analysis of all of the available information and studies in the country. And we believe that the numbers show that our health care plan will put us on track to lower deficits, lower interest rates, and increased job creation.

Now, on the issue of the overall effects of the plan on employment, a number of people have claimed that the reform will cause a reduction in employment. But I want to emphasize that we have looked at this question very carefully. We have looked at all of the models and all of the data that are available, and our bottom line here is that we do not have either the models nor the data that would be required to yield a precise estimate of the employment effects of health care reform.

In many areas of economics we do have models that are tried and tested and we can make a fairly good prediction with a fairly good amount of faith. Standard models would allow us to make precise predictions about how a tax increase or a spending cut would increase aggregate output of our employment. But there are no—and

I want to emphasize, no existing models that allow us or anyone else to predict the employment effects of health care reform with the same degree of precision.

You might ask why this is so? I am sure that question is going through Mr. Thomas' mind, why is that so? This is because the appropriate model to answer the question would have to make distinctions both between firms who currently provide insurance and those who do not, and they would also have to make distinctions about the many ways that firms in either group might respond to a change in their health care costs.

This is not a situation in which we are starting with no firms providing health insurance and we are mandating all firms to provide health insurance. This is a situation in which most workers today receive health care coverage from their employers. Many employers will benefit immediately in terms of lower costs. The entire business sector will benefit by the end of the decade. Some firms will have to pay more.

And there is no model which allows us to make this kind of distinction and then furthermore, you then have to say, of the firms who are better off, how do they respond? Do they increase wages? Do they increase employment? Perhaps they reduce prices.

Or let's take a firm that might have to pay more. Maybe they slow down the rate of growth of wages. Maybe they reduce employment. Maybe they increase their price. Maybe they cut their dividends. Maybe they figure out a different way to organize.

There are many, many responses that firms will make to this change and there is no model that captures all of those responses. In addition, individuals can do a lot of things which would affect the level of employment. Some individuals might decide to start new businesses because in our plan we would have 100 percent deduction for health payments made by the self-employed.

Maybe we will get an increase in the number of self-employed individuals. I would predict we will. We are certainly likely to get a movement of individuals out of welfare because many people who are locked into welfare report that they would like to leave welfare and would leave welfare if they could keep health insurance for themselves and their children. This would have to be built into the model. You have to know what people will do and how that will affect employment.

Finally, retirement. How will people respond to the retirement benefits or just simply to the fact that an older worker under this plan will be able to achieve insurance at a much lower rate? The older worker might simply decide to retire. That changes the employment picture. How do you make that prediction?

So our conclusion, in the absence of an appropriately specified model, is that we could generate either small net positive numbers or small net negative numbers on the employment effects of our models. And whether we got a positive number or a negative number would depend upon our assumptions. For example, if we assume that all the firms that were better off responded by employing more people, we would tend to get a positive number. If we assumed that all the firms that are better off responded by higher wages, we wouldn't get the same number.

So we have looked at a variety of runs of the existing models, all of which are flawed because they don't make the distinctions that need to be made.

And we conclude, as several private sector economists have concluded, that the net effect of our health care plan on the aggregate employment level is likely to be small. Our internal estimates suggest a range of plus or minus of one-half of 1 percent of the aggregate employment level. That is consistent, for example, with a study that you are going to hear about later this morning by Jacob Klerman indicating a small net negative number in that range, and a study that has been announced today by the Economic Policy Institute indicating a small net positive number in that range.

So again, we have concluded that the net effect of the health care plan on employment is likely to be small—plus or minus one-half of 1 percent of the aggregate employment level.

So on balance I think when we discuss the health care plan, we are certain that it will be beneficial for the economy. The employment effect is likely to be very small. It is really not the main effect. The main effect is on security. It is on mobility. It is on flexibility. And it is on increasing the efficiency of one-seventh of our economy.

Thank you, very much.

Chairman STARK. Thank you.

[The prepared statement follows:]

Testimony

of

Dr. Laura D'Andrea Tyson
Chair

Council of Economic Advisers
before
the

House Committee on Ways and Means
Subcommittee on Health

Thursday, November 4, 1993
11:00 a.m.

THE ECONOMIC EFFECTS OF HEALTH CARE REFORM

Thank you, Mr. Chairman, for the opportunity to come before your Committee to discuss the economic effects of health care reform.

The United States is facing a health care crisis. The rapidly rising cost of health care hurts businesses, depresses wages, and contributes to fiscal imbalance. The lack of health security makes many individuals afraid to leave their current jobs, discourages others from working for small businesses or becoming self-employed, and keeps people on welfare instead of working.

Reforming health care is a difficult challenge, but one that we must face. Let me first outline the problems that force us to take action, and then I will discuss the economic effects of the Health Security Act.

Why Reform Health Care?

There are five reasons why urgent health care action is needed.

The first problem is that our health care system does not provide security to individuals. When people get sick, the cost of their insurance can increase dramatically, or they can be dropped from coverage completely. This situation is a result of risk selection practices on the part of insurers. Insurers spend large amounts of money trying to select good health risks, and avoid

bad risks. This practice is profitable for any one insurer but is socially wasteful. After all, someone must cover the costs incurred by people who get sick. The result is that many people cannot get coverage, and many more fear for their ability to get coverage in the future.

The second problem with our health insurance system is that it interferes with the employment decisions of individuals. Almost 40 percent of insurers exclude pre-existing conditions from their coverage of newly insured people, thus locking many people into their current insurance policies and jobs. Surveys show that up to 30 percent of employees feel "locked" into their jobs. Some do not form small businesses or become self-employed because of the difficulty of obtaining insurance. Finally, many people remain on welfare because they will lose their Medicaid coverage if they take a job. If we are to adapt to changing domestic and international economic circumstances, we must not penalize individuals every time they change or lose a job.

The third problem with our health care system is that the number of people who do not have access to affordable insurance is large and increasing. Over 37 million people do not have health insurance. And this is not a predicament unique to the unemployed. Three-quarters of all uninsured people are in working families, and over one-third of the uninsured are in families with at least one full-time year-round worker. We have a system in which millions of people, many of them in working families, cannot afford the rising costs of health care coverage, and they face the risk of being financially crippled by events beyond their control.

It is a myth that insured people do not need to worry about the uninsured. Under our current system, when the uninsured face catastrophic costs, the insured pick up the bill. Currently, the uninsured pay only 20 percent of the health care costs they incur, while the privately insured pay 130 percent of their actual health care costs. The uninsured receive more costly care than the insured, because they seek treatment in emergency rooms when they have acute problems, rather than seeking treatment from a physician at an early stage of their illnesses. We know that preventive actions reduce health care costs. For example, a recent study at the University of California at San Diego found that hospital care for babies born with no prenatal care cost an average of \$2,200 more than corresponding care for babies whose mothers received adequate prenatal care. The cost of the prenatal care was only about \$1,000 per pregnancy.

The fourth problem with the health care system is that health care costs are high and rising. No other country in the world spends more than 10 percent of its GDP on health care. The

United States spends 14 percent. American consumers spend more on health care than on fuel oil, electricity, natural gas, other household operations, oil and gasoline, local transportation, furniture, and other household equipment combined.

The fifth problem with our health care system is that it is riddled with market failures, excess supply, and inefficiencies. These distortions are the inevitable consequence of insufficient competition: many consumers have little or no choice in the health insurance they receive; and many providers have little or no incentive to control costs. Despite our massive commitment of resources to health care spending, the United States ranks 19th out of 26 countries in infant mortality and 18th in life expectancy. We lose an estimated \$80 billion a year to fraud and abuse. Over 5 percent of our total health care spending--conservatively \$45 billion in 1992--covers administrative expenses and paperwork. As many as one-third of common medical procedures may be unnecessary and inappropriate. Hospital prices continue to rise even though hospital beds are in excess supply in many parts of the country. HMO experience indicates that the cost of medical care can be cut by as much as 10-20 percent without reducing the quality of care.

These diverse indicators paint a compelling picture of the misallocation of resources in our current health care system. Perhaps the most important economic reason for reform is to improve the efficiency of this system. This in turn will make resources available to cover the uninsured and to address other pressing economic and social needs.

The Economic Effects of Reform

The Health Security Act addresses these fundamental problems in the current system. It will lower costs, provide security, increase job opportunities and increase the efficiency of the economy. Many businesses will see their costs fall, and many others will have access to coverage previously denied them. Slower cost growth will allow workers to enjoy faster growth in their real wages, and reduced job lock will increase their ability to find better jobs. Let me describe what I believe to be the important economic effects of health care reform.

First, many employers who currently offer health insurance will see their costs fall immediately. Under the Health Security plan, every individual will receive health insurance. Eliminating uncompensated care in the current system will lower costs to

businesses that provide care, thereby making resources available for increased wages or additional hiring. Eliminating corporate "free riders" will also reduce spending by companies that currently provide health benefits for their employees and for their spouses who are not covered by their own employers.

Second, the Health Security Act gradually lowers aggregate business spending on health insurance. Although the business sector as a whole will initially pay more for health insurance, the reduction in health care cost growth lowers the growth of premiums over time. In fact, by the end of this decade, we estimate that aggregate business spending on mandatory services covered by the Health Security plan will fall by over \$10 billion.

Businesses can do many things with the resulting cost savings. They can: hire more workers; raise wages or provide better benefits for existing workers; invest in more plant, equipment, education and training, and research and development; increase dividends to shareholders; or lower prices, thereby leaving consumers with more income to spend on other goods. Each of these outcomes will have a stimulative effect on the economy and will increase employment. Economic research has not reached clear conclusions about how to apportion the savings among these effects. Almost all models suggest that wage increases are a likely response, but they differ about whether all of the savings will flow into wage increases. Nevertheless, the effects of lower health care spending are clearly beneficial for the economy.

Small businesses will particularly benefit from the Health Security Act. Currently small businesses that provide insurance face administrative costs of up to 40 percent, while large businesses face costs of only 5 percent. Under reform, administrative costs for small firms will fall by up to 25 percentage points. Additionally, many of those currently insuring small firms will receive subsidies for on their premiums.

Although small businesses that do not currently provide insurance will pay more, they are likely to receive discounts to make health care coverage affordable. There is a common myth that small businesses cannot afford to pay anything for health insurance. In fact, many small businesses report they would like to provide health insurance for their employees if it were more affordable. According to a recent study for the NFIB performed by Charles Hall of Temple University, 64 percent of small business owners would like to provide some or better insurance for their workers. When asked why they do not offer insurance, the most common response (65 percent) was that premiums are too high. Ninety-two percent of small business owners agree that the cost

of health insurance is a serious business problem. Under the Health Security Act, with affordable health insurance and discounts for small businesses, this will no longer be the case.

Third, the Health Security Act will result in greater employment in the health care sector in the short run and a more efficient health sector in the long run. With the increase in the number of insured Americans and the decrease in the administrative burden of health insurance, there will be a significant expansion of employment of health care providers and a decrease in employment of health administrators and insurance workers. As the cost savings of the plan begin to accrue, employment in the health sector will grow more slowly, although there will be no absolute decline in the number of employees.

Over time, the health sector will become more productive. This benefits all of us. We will be able to have the same or better health care as well as more investment, research and development, or just plain goods and services.

Fourth, the efficiency of the economy will also be increased by reducing job lock and welfare lock. By providing health care security, the reform will give workers the freedom to move to jobs where they might be more productive without having to worry about losing their health insurance. Small firms should particularly benefit from this, since they often have the hardest time attracting highly skilled workers. In addition, firms should be more willing to hire workers with pre-existing conditions because the new system does not penalize individuals with a prior illness. This allows for better, more efficient matches between employers and employees and increases the efficiency of the economy.

Some workers may decide to leave the labor force completely when there is continuous health coverage. Evidence suggests that about 350-600,000 people will decide to retire early under health care reform. This increase in voluntary retirement may increase employment opportunities for younger workers.

Financing Reform for the Federal Government

Health care reform will also work to lower the Federal budget deficit. Even with the Economic Plan that was passed in August, the Federal government will again face rising deficits unless health care costs -- particularly in the Medicare and Medicaid programs -- are brought under control. Without health care reform, we face the certainty of higher deficits, higher real interest rates, and continued fiscal instability. Managing the Federal budget requires health care reform, just as the lack of security requires universal, comprehensive coverage.

To meet our health care needs, the Administration proposes to spend money in five major areas. The first is premium discounts and subsidies. We estimate the Federal cost of these discounts at \$274 billion over the 1995-2000 period. This is the amount that is capped in the law, after deducting the required maintenance-of-effort by the States. The net cost of reform will be less, however, because reform will lead to predictable savings in Medicaid and Medicare as former beneficiaries of these programs receive private insurance. We estimate the net cost to the Federal Government of the discounts at \$161 billion. This includes a subsidy "cushion" to account for effects that we cannot fully model, such as changes in employment behavior or the additional costs of induced retirement occasioned by the implementation of our plan.

The 100 percent tax deductibility of health expenditures for the self-employed proposed in our plan is the second area that will require new Federal resources. The new deductibility provision will put the self-employed on the same footing as wage and salary workers.

The third area of new spending is spending on new public health initiatives, ranging from WIC enhancements to school-based clinics. We project spending of \$31 billion between 1995 and 2000. The last two areas of new spending are two new programs for the elderly and disabled: a drug benefit for Medicare; and a new program of home and community-based long-term care. The total cost of these spending initiatives is \$332 billion over the 6 year period.

We propose to cover these new costs through 6 sources of savings. First, there are Medicare savings of \$123 billion. These savings are from specific, scorable program cuts -- the type that the Congressional Budget office has regularly credited in the past. Medicaid savings of \$65 billion are the second source of savings. These savings come from two sources: phasing down the Disproportionate Share payments needed in the current system because some people are uninsured; and taking advantage of the fact that the cost of Alliance plans will grow at a less rapid rate than the projected cost of Medicaid coverage in the future. The third source of funds is savings from the VA, the DOD, the Federal Employees Program, and the Public Health Service, amounting to \$40 billion.

Fourth, we propose to increase tobacco taxes and to introduce a corporate assessment which together will raise \$89 billion. A \$.75 increase in the cigarette tax raises \$65 billion, and a 1 percent payroll assessment for firms that choose to form corporate alliances instead of joining the regional alliance raises \$24

billion. The corporate assessment is designed in part to require that all firms contribute to the costs of medical research and other public goods, as well as to recapture some of the savings these firms might be expected to experience from reduced cost-shifting.

Fifth, our plan will provide another \$68 billion of additional savings from several sources, including revenue gains from slower health care cost growth, from changes in cafeteria plans offered by employers, from changes in some other tax provisions, and from contributions of corporations benefitting from early retiree provisions. Finally, our plan generates \$4 billion of lower debt service.

In total, we raise \$390 billion through these sources of savings. Since our projected spending is only \$332 billion, there is \$58 billion of deficit reduction.

We believe that our numbers are credible and based on careful analysis of all of the available information. We also believe that they put us on track to a long-term program of lower Federal deficits, lower interest rates, and increased job creation.

Summary Conclusions on the Likely Economic Effects of Health Care Reform

As you know, some have claimed that the Health Security Act will cause substantial damage to the economy. There is no denying that some firms and individuals will pay more than they did prior to reform. In particular, the Health Security plan will increase costs for some young, single individuals as well as for firms that did not previously offer health insurance. The vast majority of Americans, however, will benefit from the reduction in health insurance costs, the portability of coverage, lower administrative costs, the reduction of job lock, the lower costs for small businesses and the self-employed, and the reduction in welfare lock. In addition, as already noted, many employers, both large and small, currently providing insurance will enjoy lower costs immediately and the business sector as a whole will enjoy lower costs within three years of the plan's full implementation.

Neither the models nor the data that would be required to yield a precise estimate of the employment effects of health care reform are available. In many other areas of economics, there are models that have been tried and tested for decades, and economists generally place a good deal of faith in the outcomes they predict. Standard macroeconomic models, for example, can make reasonably precise predictions about how a tax increase or a spending cut will affect aggregate output or employment.

But there are no existing models that allow us to predict the employment effects of health care reform with the same degree of precision. This is because the appropriate model for such an exercise would have to make distinctions both between firms that currently provide insurance and those that do not and among the many ways that firms in either group might respond to a change in their health care costs. Such a model would also have to predict how individuals might respond to new incentives in the plan, particularly those affecting small business creation, job mobility, welfare lock, and retirement.

In the absence of an appropriately specified model, one can generate either small net positive or small net negative effects of our plan on employment, depending on the assumptions one is willing to make in existing models -- demonstrating the old adage that you get out what you put in. Not surprisingly, several private-sector economists have concluded, as we at the CEA have concluded, that the net effect of our health care plan on the aggregate employment level is likely to be small--our internal estimates suggest a range of plus or minus one-half of 1 percent of the aggregate employment level. This is because although there are some factors in the plan that will tend to decrease employment, there are others that will tend both to increase employment and to change its composition. These offsetting factors are likely to cancel each other out, although over time as business health care spending falls below baseline, the factors encouraging an increase in employment and wages are likely to strengthen.

On balance, I am certain that the Health Security Act is good for American business and the American people. It diminishes job lock and welfare lock and allows more people to become self-employed. It gets health care costs under control. It guarantees security to all Americans. It reduces waste and inefficiency in one-seventh of our economy. And it lowers the budget deficit. Reorganizing our health care system to use our scarce resources more efficiently will help us realize our goal of realizing higher living standards for ourselves and our children.

I will be delighted to answer any questions that you may have at this time.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I fully understand the difficulty of open-ended questions in trying to determine the result of anything with the dynamic model. I was just amazed that the administration was able to do it when they presented their package by indicating that the \$124 billion for Medicare savings was going to go directly to the long-term care and to the drug benefit. This was done with an arrow going directly across showing not only how much money was going to be produced, but even where it was going to be spent in the system. That was a little naive in terms of explaining reality.

Nevertheless, that was the position that they held. Let me ask you a question which is not open-ended, a closed question based upon the bill that has been submitted.

The President and the First Lady have said one of the primary virtues of universal coverage will be the end of cost shifting in the system, which currently can be attributed to a number of different structures. My concern is that in looking at the way the bill operates, there are a number, in my interpretation, of cost shifts that occur under the plan.

For example, in an attempt to not have an open-ended entitlement, you have capped entitlements for certain income levels, and that they do not have to pay higher than a fixed percentage of their income for the services which may or may not pay for those services.

In addition to that, you are going to have a number of people who are at a very low income level, for example, at or below the poverty level if they are not on Medicaid or SSI, they will be required under the President's plan to pay a copay. It will be a reduced copay, but they will be required to pay it.

You are going to get in some areas fairly significant bad debt from people getting services who don't pay. My understanding is that those dollar amounts where an alliance falls short will not be covered by any Federal moneys, but will be covered by an adjustment within the alliance area. That is a cost shift within the structure.

But of even more concern, I think, is an unintended consequence of trying to cap entitlements after you set up the structure. What seems clearly the intent of the plan to me is a built-in cost shifting on the basis of State payments, where the health alliances have to get their funds from the amount of the bid accepted or adjusted under some kind of a cap adjustment if the money is not otherwise available.

The Medicaid copayment is only 95 percent of the amount and the Social Security per capita premium. Now, if that money is not sufficient to cover the cost of the health benefit package in a particular area, the rest of the beneficiaries under the alliance are going to have to absorb that cost.

My concern is that the Federal Government payment is a phasein on the Medicaid payments to the alliances. It is not an upfront full amount. It is an over-the-years phasein. So there appears to be a built-in money making scheme by cost shifting purposefully as a result of the Federal and the State underfunding the sup-

ported recipients' portion of the health care benefits. It is a clear cost shift on to those who are paying the full amounts.

Now, what kind of impact is this going to have on minimum wage job opportunities within a given alliance area since the only guaranteed structure for an alliance is a consolidated metropolitan statistical area? Is there going to be enormous political motivation to structure alliances in ways that they don't drive employers out of a given alliance?

Has any of that been examined in terms of a closed system of the way in which it purposefully cross-subsidizes and underfunds governments' portions for supports of alliances? Has anyone looked at this to determine job impact?

Ms. TYSON. Well, I think that there are a number of points that you raise. And let me try to touch upon several of them, and I hope I don't miss the main one.

Mr. THOMAS. First of all, do you agree that built into the plan is either inadvertent cost shifting from either low income people who have their amounts capped and a purposefully built-in cost shifting because the underfunding of the State and Federal amounts? Do you agree with that?

Ms. TYSON. I don't think there is any purposeful underfunding of the State and Federal amounts. We have built into our financing—

Mr. THOMAS. First of all, Medicaid is 95 percent of the amount that they are supposed to pay. That alone is a 5 percent underfunding. It has got to come from somewhere, doesn't it? If the Federal support is phased in over time, then you have a phasing out of the underpayment which has to be recovered at the alliance level. That is a built in underfunding, therefore it is subsidized by the other people in the alliance.

Now, whether it was intended or not, we will have to ask whoever wrote that section, but it is certainly there in black and white.

Ms. TYSON. First of all, on the issue of Medicaid—and then you also mentioned the issue of bad debt and then on the issue of general issue—on the issue of Medicaid, it is my understanding that Medicaid will be paid for at the current levels reduced by a 5 percent discount for managed care.

So the 95 percent comes from current levels, less a 5 percent discount for managed care which is a common approach today. This is not a deviation with current practice.

That would leave us with essentially the same cost shifting issue that we live with today. It is not changed. It is not different. That is the first thing I would say.

Mr. THOMAS. I understand that, but that is part of the problem of the argument on cost shifting of the current system today. You incorporate and move over the current cost shifting problem into the new system.

Ms. TYSON. That is correct on that point.

Mr. THOMAS. The other problem is that you have now put a cap on the subsidies so that we may or may not have enough money and when we bump up against the cap, and that is another whole argument.

Ms. TYSON. When you are talking about the cap on the entitlement subsidies—

Chairman STARK. Will the gentleman yield? I think the gentleman has hit on a technical problem that may or may not have anything to do with the employment effects, but if I understand what you are saying and if I understand the system, in an alliance, they would take the current Medicaid rate. And let's assume in California that that is 60 percent—

Ms. TYSON. Right.

Chairman STARK. —of average charges. I am not sure on cost, but 60 percent on charges and you lower than by 5 percent and then the employers, through their other plans, will have to fund the plan for enough to pay for an amount that is more.

In other words, it won't cost shift after the first cut because the costs will stay parallel, but you institutionalize a major differential in reimbursement for the Medicaid population, and I am not sure that is a good thing to do, but—

Ms. TYSON. You have incorporated the current—

Chairman STARK. It is more on how it is going to affect the providers than the small employer.

Mr. THOMAS. Here is the dynamic on the unemployment situation and available employment that I am concerned about. You take that dynamic in terms of the Medicaid population that has been built into the system, then you take the capped entitlement and the capped payment section, which once again will affect the poorer folk in terms of not paying, if you will, their fair share of the cost of the health plan within the alliance. When you begin looking at where employers will go based upon those alliances that have captured a significant number of those folks, we are basically talking about urban areas.

The only guaranteed alliance structure in the President's plan is a consolidated metropolitan statistical area, that is, L.A. County with some surrounding counties would be a guaranteed alliance. What you have done then is created a positive financial incentive for employers to leave that area and go some place else because they are picking up an enormous subsidized hidden health care cost if they stay in that area built into the plan.

Has anyone looked at the economic impact of flight from alliances that are required to absorb the subsidies that are built in the plan?

Ms. TYSON. Number one, we are cognizant of the possibly—we have built in a 15 percent cushion of subsidies into our overall subsidies estimates. And of the things we are cushioning for, one of the things we are cushioning for is the attempts of States to draw regional alliance boundaries in the most favorable possible way, and they might be influenced by employers to do that as well. So we recognize this as a problem. And we do have a cushion to cover.

That is the first thing I would say.

Mr. THOMAS. If you recognize it as a problem, why did you guarantee the only precleared alliance structure to be a consolidated metropolitan statistical area? That is guaranteed to be an alliance. And if you draw it along those lines which guarantee that you get the maximum lower income people in that consolidated metropolitan statistical, you pick up all the major urban population centers. That is guaranteed in the plan.

The National Health Board does not get to approve or disapprove that. It is automatic, presumed to be acceptable.

Ms. TYSON. Can I say one other thing on this? I do not know why we did this. And this is a level of question which you will have to ask the Secretary of HHS.

Mr. THOMAS. I asked them. They said ask you.

Ms. TYSON. No, I am sure they did not say that. But the employment issue, I think, I can deal with, and that is, look, we have a system now which has huge differences in the cost of the same medical service across States, across regions in the States.

We have a huge amount of differential cost shifting that goes on within a State. And I think that we will vastly improve the differences that exist. We are going to, over time through the process of community rating and by eliminating most of the cost shifting issues in the system, we are going to reduce the differentials and reduce the amount of cost shifted uncompensated there.

There may be a residual left, if what you say is true. But if it were the case that employers were constantly on the move on the basis of whether they paid a higher rate in Los Angeles than in San Francisco or in Louisville, Kentucky, than in Omaha, Nebraska, then I would dare say employers would be moving all the time in this country because one of the most dramatic things about the system we have is how dramatically different the price for the same service is both across States and even within the States.

So we are going to take a system which is riddled with this problem and reduce the scope of the problem substantially. I think it will cause the kinds of issues you are concerned about to be improved.

Mr. THOMAS. Are you aware that an employer can hire people outside the alliance and then have them come and work inside that alliance area, paying the health care cost of where they come from outside that alliance?

Ms. TYSON. Yes. But if you are talking about a region—if you are talking about drawing the alliance boundaries within an area where most people could commute to work, if you are talking about that problem, we have taken that problem into factoring our subsidy cushion.

Mr. THOMAS. Take a look at the District of Columbia and try to explain that away.

Chairman STARK. Mr. Lewis will inquire.

Mr. LEWIS. Thank you very much, Mr. Chairman. Good to see you Madam Chair.

I know you come here as an economist, but I would like for you to speak to us about what Immanuel Kant the philosopher called something being good in and of itself. That health care reform is good in itself. I know you say it will lower the Federal deficit, but I am not one of these that buy into this mass hysteria about the deficit. So, could you speak about why health reform? Why is it good in and of itself? Is it good in and of itself?

Ms. TYSON. Well, I think this is an easy question in the sense that I tried to make the economic case for reform. I think health care reform is a desirable goal. I think it is desirable to have health security for all Americans and the ability to get health care early

on, to get the most successful outcomes and the least costly outcomes.

It turns out they are also good for the economy. I think here we don't have a conflict, we don't have to make a trade-off here. Sometimes there are things that are good but when you look at the economics you say, if you look at the economics, they are not so good.

This is a situation where the goal of health security and universal coverage for all Americans which are desirable goals that will benefit the society, those goals are also good for the economy or the realization of those goals through this plan will have beneficial effects on the economy.

Mr. LEWIS. You stated in your prepared statement that evidence tends to suggest that about 350,000 to 600,000 people may be retired from their jobs because of health care reform. Could you elaborate?

What sector would these people come from?

Ms. TYSON. Well, the exact sector of the economy is not clear. The reason we have come up with that range of estimates—again, what we have tried to do here is tried to look at what will happen to job mobility, what will happen to welfare lock, what will happen to retirees, and we have gone into the economic literature and looked at studies which might have something to say in the retirement case on how sensitive a retirement decision might be to the price and availability of health insurance.

That is one thing, not the only thing, but one thing that affects a decision to retire or not retire.

So using the existing studies which look at all possible reasons to retire or not retire, we conclude that with the system of universal coverage and community rating, which reduces dramatically the cost for someone aged 55 to 64 of achieving comprehensive benefits, that reduction in cost or that improvement in access to health insurance regardless of whether you are employed over not employed at age 55 to 64 may encourage an additional 350,000 to 600,000 people to decide on early retirement.

So the argument is that these are the people who are currently not retiring because insurance is simply too expensive for them to realize on their own with current premiums that are not community-rated and are therefore high for those aged 55 to 64.

Mr. LEWIS. Let me come back again. This may not seem to have much to do with health care reform, but as an economist do you sometimes think that maybe as a society and as a people that we are becoming too preoccupied with lowering the Federal deficit?

Ms. TYSON. I think that we—the important thing for us to do is to have the deficit on a credible and sustained long-run path of reduction. What we faced—when the Clinton administration took office was, as far as the eye could see in the future, that structural deficits that were rising.

That is regardless of the state of the economy, whether it was booming or whether it was in recession, the deficit was not going away. It was getting bigger and as a consequence of that, the amount of debt that the government had to issue was growing relative to the size of the economy.

Those two trends are not sustainable in the long run. With the budget package passed in August, we have the economy now on a

downward trend—that is, the deficit declines relative to GDP and the debt relative to GDP.

This plan will do some additional adjustment over a 5-year period. It is \$58 billion over a 5-year period. I think that we need to continue on this path. It can be a gradual path, but it must be a credible path and a sustained path of deficit reduction.

Mr. LEWIS. Thank you, very much. Thank you, Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. I just have one question. The Congressional Budget Office did a study in which they said that the single payer system would reduce the expenditures for health care by \$325 billion over the next 5 years.

What impact would that have on the deficit?

Ms. TYSON. Was this an estimate of Federal Government spending or total health care spending?

Mr. MCDERMOTT. Total health care spending.

Ms. TYSON. Well, to answer that question you would have to make the decision—in discussing what the effects of total health care spending are, you have to ask yourself how those savings would be used in the system.

If we assume that the savings would be used in the system to invest more or make higher wages, they would generate rapid growth in the rest of the economy, obviously that would cause an increase in tax revenues and an increase in employment and output and a reduction in the deficit.

I think when you are asking what the effects of an overall reduction in health care spending are, you really have to ask how the rest of the economy would respond to those additional resources that would be made available for something else.

Mr. MCDERMOTT. That is what I am asking you. You are an economist. I am not. I am wondering what kind of assumptions you would make about what would happen with that kind of a savings in the economy.

I know you can't give me necessarily a number, but I want to hear you talk about it.

Ms. TYSON. OK. Let me take the Federal spending portion of this first, and then do the private sector portion.

If you ask the effects on the economy of any reduction in Federal spending on health or anything else, you would have to really ask a two-part question.

Cutting Federal spending by itself actually tends to reduce spending in the economy. The government spends just like the private sector spends. The clearest manifest occasion of this is in defense right now. We are seeing month after month, quarter after quarter, the government spends less on something, and that actually causes a reduction in demand. That actually slows down output growth. It slows down employment growth.

On the other hand, as the government spends less on anything, and this would be a big amount of money, presumably that reduces the deficit and that should cause interest rates to continue to fall, and that would stimulate private spending, consumer spending, investment spending, housing investment, and so the private sector could spend more, particularly on interest sensitive parts of spending. That is what we are seeing now.

What we are seeing now is that the budget plan and the anticipation of deficit reduction has led to lower interest rates. Lower interest rates have stemmed an investment-driven recovery. That is what we are seeing. Private investment is up. Residential investment is up. Consumer durable spending is up.

So in this kind of analysis, I would speculate that as with any other form of savings or cutting of Federal spending, you would see the direct effect would be to slow the economy down, but in fact the interest rate effect would allow the economy to continue to grow, and you would see a shift, but what you would fundamentally see is a shift in the spending composition of the economy.

The private sector would spend more. The public sector, the Federal Government would spend less.

Now, as far as what would happen—

Mr. McDERMOTT. Are you saying that all the savings that the government would get, they would return in lower taxes, or are you saying that they would use—

Ms. TYSON. I just made the assumption that they reduced the deficit. I didn't make any assumption about taxes.

If you want to return it to the private sector in terms of lower taxes, then that would be another way—then the stimulus to the private sector would be different. The story I told you was the government spends less, interest rates fall, and that stimulates the private sector.

Another way to do this is the government spends less, it reduces some taxes some places in the system, and that stimulates the private sector.

Mr. McDERMOTT. Is the third option that the government spends less and has money for investment in other sectors?

Ms. TYSON. Yes, that was my next option. That is what I said, the fundamental issue here is what we would say would happen is there would be a shift in the composition of spending. Either the public sector would spend less and the private sector would spend more, or the public sector would spend less on and health, more on education, and more on retraining and more on crime prevention, whatever.

So it depends very much on what the Federal Government did with the savings it generated.

Now, within the private sector, I think what I said in my opening comments suggests what we think. We believe that because of a lack of incentives in the current health care system that there is a considerable amount of inefficiency or misallocation of resources in the health care sector itself.

And our reform is meant to gradually slow down the rate of health care spending, freeing up resources for the rest of the economy. Now, how would that show up? Employers would see lower premiums. They could respond to that in all the ways that I mentioned before. They could—economists tend to think that when you have a change in the cost of insurance to a private employer, the most likely outcome would be a change in the rate of growth of wage compensation over time. That is, over a 20- to 25-year period.

If you look at the evidence, it suggests that American workers have by and large paid for the rising cost of health care by a reduced growth in their wages. That has been the primary response.

So if you do something to change the trajectory of health care spending over time, the primary response—and again this is over a decade or so, it doesn't happen overnight—the primary difference would be a change in wage growth. That would be an economist's standard prediction.

Mr. McDERMOTT. A prediction that you would begin to see an increase in wages that have been essentially flat or actually declining in the years before?

Ms. TYSON. That is right.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman. Mr. Tyson, welcome.

I wanted to first of all to be mindful of your role as Chairman of the Council of Economic Advisors. It doesn't serve us well in this hearing to delve too deeply into the credibility of the numbers.

We want to talk about the assumptions; am I correct?

Ms. TYSON. The assumptions.

Mr. GRANDY. I assume a number that you generated, is the one that you addressed with Mr. Lewis' question about the potential early retirees. Is that a number that we can be comfortable with? Is that a number that came out of a report that you and Mr. Reich generated?

Ms. TYSON. We can be comfortable that these numbers are based on the best empirical estimates in the literature. That is our degree of comfort.

Mr. GRANDY. You state 350,000 to 600,000. That is good enough to me. I don't have a problem with the number. It is the assumption that I want to talk about. That is the whole question of why, when we know in our society that there is an ever increasing ratio of retirees to workers. We know that those retirees usually are at the upper income spectrum, and they have, over time, become some of the largest beneficiaries of Federal programs. I want to make sure I understand the program that we are talking about, but as I understand it, the early retiree program would obligate the Federal Government to pay 80 percent of the person's retiree health benefit and the individual and the employer to pick up the other 20 percent. That is correct, isn't it?

Ms. TYSON. Yes.

Mr. GRANDY. However, that 80 percent that the Federal Government is going to pay is in no way means-tested. That is wherever you are in the work force. Whatever your net worth would be, if you were in this program, you would pretty much get the same subsidy regardless of income. Isn't that correct?

Ms. TYSON. Yes. On your 20 percent that you pay.

Mr. GRANDY. Not on the 20 percent, but the 80 percent, the lion's share. This is what I don't quite understand. To me what that is going to do is basically say to people who have managed their money prudently and saved and planned for their retirement, that they were essentially chumped.

I say that because people who didn't are going to get an early retiree benefit, four-fifths of which is going to be paid by the Federal Government. It may be even more if the employer kicks in, depending on what the relationship was before they retire.

I just wonder about what that says about our commitment to savings, and rewarding work as opposed to punishing it. Finally, why we would want to take these people, who very often are some of our most productive workers and certainly some of our most intelligent, and give them the opportunity to retire early? Why give the employer the incentive to get rid of them if they wanted to because oftentimes these folks would be the most highly compensated?

It is not hard to understand why business would like this plan. If the Federal Accounting Standards Board is correct and we are looking at a potential of unfunded liability of \$20 billion, and they can wipe some of that off their books, all the better. If you are an advocate for a senior group or early retiree group, this is a good deal, too.

But I guess what I don't understand, Mr. Tyson, is the public policy merit of this health care plan creating this kind of sweetener. I think it works against productivity and sends a pernicious incentive into the marketplace to get some of our most productive people to retire early and become, rather than taxpayers, tax collectors and larger beneficiaries.

And I guess I would like to hear the reasoning, the assumptions and the ideas behind that. You don't have to use a single number, if you don't want to.

Ms. TYSON. OK. I think it is important to begin discussing the early retiree issue with the observation that if we have a system based on universal coverage and community rating, and there were no special schemes other than the notion of community rating with universal coverage, those two things alone—and they are critical features of our system—change dramatically the ability of individuals to choose early retirement.

Forget right now that the government is picking up the 80 percent. They change dramatically the ability of the individual to make that choice because essentially right now we have a situation where if you were in the 55 to 64 age category, and you want to retire early, the cost of insurance to you is very, very high.

So, unless you want to undo community rating and universal coverage, which would basically undo the entire system that we propose to put into place, you cannot get around the fact that 55- to 64-year-olds have now an improved prospect for choosing early retirement—they can do it. Many of them can do it. So that is the first thing.

And actually, the additional money that the government picks up, because many of those people would be eligible for subsidies on 20 percent, and even subsidies on the 80 percent, when you look at the incremental effect on the spending that we propose that come from the government picking up the entire 80 percent rather than just part of the 20 percent and part of the 80 percent, it is not the lion's share of the money.

The lion's share of the money for early retirees comes from the fact that the system makes it more attractive just by the virtue of universal coverage and community rating. That is the first thing I wanted to say.

The second thing I wanted to say is that we have of course in the revised proposals that we have now, the one that we have sub-

mitted, we are making it a requirement that during the first 3 years of the phase in of the early retirement program that companies will, in fact, be required to make a payment to the Federal Government of essentially 50 percent of the benefits that they are receiving as a result of being able to take the 80 percent, which they were paying, and see the Federal Government pick it up should their employee decide to retire.

So we have introduced for the companies that you are concerned about, the companies that are going to make money from this, we have introduced a proposal that would require them to share the benefits of the greater flexibility in the work force, the greater flexibility to restructure, to meet competition by changing their work force, they are going to get substantial benefits both the immediate benefit of a reduction in the liability, but also the benefits that come from restructuring.

We are requiring that during the first 3 years, half of those benefits would go to the Federal Government.

Finally, it is my understanding, but I don't have the exact number in front of me, that for very high income people, 80 percent pickup by the Federal Government would be means tested.

Mr. GRANDY. That isn't in any description that I have seen.

Ms. TYSON. It is my understanding that we may have added that. I would have to check on that.

Mr. GRANDY. You have, at least partially in your funding mechanisms, means tested Medicare part B by requiring a payment of some higher income level. I applaud that.

This early retirement notion, however, seems to provide a "Medicare lite," which, given the fact that we are living longer, that we are productive longer and that we have a problem with trained workers in this country, basically creates a blanket program, means testing notwithstanding, to basically use this as part of our health care plan.

I think it is going to be very costly. I think the numbers have moved around too much. Beyond that, again staying away from the numbers, the assumption of telling folks who are 55-years-old and who may have better than a third of their life to go, that they are basically going to become beneficiaries of the system, I think absolutely is the wrong direction for public policy.

Ms. TYSON. I wouldn't expect that this issue is the reason why most people retire. I mean, it is the case that the system, without the government pickup of 80 percent, makes early retirement look more attractive.

Mr. GRANDY. It is not a reason to retire. However, if I am an employer and I am paying you a high wage and I can get rid of you and give you a buy out and know that your insurance is going to be covered, it is an incentive for me to reconfigure my work force.

That is the problem that we are disintermediating from one generation to the other without an improvement in production.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. Let me take 30 seconds of my time to repeat on the record what I told you yesterday about misstatements in The New York Times article on your effectiveness on being in my office presenting arguments for NAFTA.

You are a very effective spokesperson for the administration on that issue. I am not going to tell you that I am voting for it. Not that effective yet. We are still working on it.

Mr. Thomas mentioned the issue of cost shifting. And I certainly agree with the dangers of cost shifting in our current system, and the impact it could have on any health care reform system. We currently see a great deal of cost shifting between those people who are uninsured and use our health care system and don't pay their health care bills to those of us who have a private insurance.

And we see cost shifting to those people who have health care through some insurance program that doesn't pay its fair share of the teaching costs or uncompensated cost to those of us who don't have that opportunity. And we see cost shifting today that occurs between what Medicare and Medicaid pays toward health care costs and again to those people who are privately insured.

I think it is important to point out that the President's proposal moves substantially to reduce and eliminate the cost shifting that exists in our current system, particularly as it relates to those people by making sure that all people pay for health care rather than some of us pay for people who don't have any health insurance, and for equalizing out the burdens of teaching costs and uncompensated care.

If I understand the President's proposal, it freezes at least currently the Medicaid discrepancies and sets up a separate pool for Medicare. And I agree with Mr. Thomas, I think we should look as we consider this legislation to ways over time of eliminating those inequities and those cost shifts that occur, because it does distort the efficiency of the system. And we find that as we bring Medicaid, particularly into the regular health care system, we save money. And although Medicaid is not paying its appropriate share today, it is still a very costly program.

We should be able to have, I would hope, a cost-effective system and use some of those funds to make commitments over time that Medicaid will pay its fair share. And I would hope that as we go through this process, we would look for ways of building that into any reform proposal that we pass.

Let me ask you a question if I might about comments that you made on people wining and losing under health care reform. We have seen different percentages that have been given. I don't want to get into how many people will pay more or how many people will pay less, but isn't the principal reason why there will be differences among the masses of people is the reform known as community rating. That when you go to community rating there is going to be winners and there is going to be losers?

Ms. TYSON. I think that is certainly a part of this and an important part, and we believe it is necessary to go to a system of community rating. That is really what insurance is about.

Insurance is about pooling individuals who have different characteristics into a common pool so that the risk is shared. If you look at an economic textbook on insurance theory, you will start out with the notion of community rating on pooling. So it is our approach of insurance reform to making insurance work.

It does mean, for example, that younger workers will pay more than they would now and older workers will pay less. It is what we were just talking about in terms of retirees, for example.

Mr. CARDIN. And just to underscore that point, I think that just about every one of the reform proposals that have been suggested by other groups in Congress include community rating as one of the suggested matters that we should do.

In fact I think there is general consensus on both sides of the aisle that health care reform should include community rating. So if we include community rating, by definition, we are going to have people who are currently in pools of very young individuals and are paying their insurance premiums based upon unrealistic pools are going to end up paying more under any of these proposals; isn't that correct?

Ms. TYSON. I think that is correct. And it speaks to the point that many of the other reform proposals are trying to handle the market failures in the insurance market. And even if you just start with that as your goal, then you very quickly get to the need to pool larger groups of people together, and community rating is one way to do that.

Mr. CARDIN. Thank you, Mr. Tyson.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Tyson, let's return to one of my favorite topics—the early retirement provision. You indicate that the employers will be asked for the first 3 years to make some contribution, however in previous hearings and discussions of the committee, this contribution comes out to about 15 percent, which is a pretty low price to ask them to pay.

Using your max of 600,000 American workers taking advantage of this provision, what would the cost be using the models of the family plan and the individual plan. Do you have any dollar amount?

Ms. TYSON. Actually the—

Mr. KLECZKA. I am looking for our 80 percent.

Ms. TYSON. If you took the 600,000, let's assume that the 80 percent is about \$2,000 each, so you are up to \$1.2 billion a year annually.

Mr. KLECZKA. So you get \$1.2 billion a year annually. That is the additional cost of the induced additional retirement. There is early retirement anyway already.

So this is the additional early retirement that might come as a consequence of this provision. I would say this could really be a inducement.

You look at two things when considering retirement: is there enough income to support the family, and, right on the heels you look at the health care. If you are getting 80 percent paid for by the Federal Government and you are liable for 20, I think you are going to take early retirement and be satisfied that that is a guarantee for the rest of your life.

Ms. TYSON. But again I would want to point out that there are many reasons why people retire. Surely most people are not—the conversation seems to suggest that most people between 55 and 64 are working solely for health insurance.

Mr. KLECZKA. No. The first thing you look at is whether or not whatever savings you have and the retirement annuity coming is enough to support the family, and second, right on the heels, is health care.

So if we are going to be guaranteeing the second part, if the dollars are there, these folks are out. And the problem I have with the proposal is that as a working person living next during to an early retiree, I am not only paying my 20 percent but his 80, so I am carrying an additional burden to pay for them and what is he doing?

I am saying if he retires and he is not looking for a part-time job, he is not a productive citizen at that point. He is going to be doing lesser things, which as I said, is not going to sit very well with the American working public.

Ms. TYSON. Let me take the point again that we are talking about—you have to—I think the person who is working next to—I am a working person, the person next to me is an early retiree. All of a sudden we have a change in system which allows for universal coverage and community rating. This person—I set it up wrong. We are both working hard.

Mr. KLECZKA. No, no, I like the first example.

Ms. TYSON. No, no, but I am going to make this person an early retiree.

Mr. KLECZKA. This person is putting the golf clubs in the trunk as you are putting your briefcase in the back seat of your car.

Ms. TYSON. We are both working hard right now, and under the current system I am paying less for my health insurance and he or his company is paying more because he is older or she is older and I am younger, not too much younger but somewhat younger, so we are both working right now, but we have very different insurance premiums being paid for us because we are not community rated.

Now, the health care reform comes into play and all of a sudden they are community rated and so am I. The premium for our employers and for our 20 percent is the same. It is not different anymore. It is really not different anymore.

Now, at that point that person can say I am going to leave my job and I am going to play golf. Do you have a problem with that? See, I keep wanting to say that part of—

Mr. KLECZKA. No, if the person wants to go and play golf, then don't ask me to pay 80 percent of his health care coverage while he plays golf.

Ms. TYSON. It is not the fact that the premium is going to be lower and they are more able to—

Mr. KLECZKA. That is not part of the equation. The principle involved here is what is—

Ms. TYSON. The important point here is that the amount of money involved for those who continue to work, the amount of subsidies involved simply with making early retirement more feasible through the universal coverage and community rating, those subsidies are the lion's share of the retiree's subsidies. It doesn't cost that much more.

It costs something for the government to pick up the additional 80 percent, but not that much more.

Mr. KLECZKA. Well, we will see.

Ms. TYSON. Can I just say that, let me just say the reason why this is here, and I think this is something people clearly feel strongly about and this is something that I think will be a continuing source of discussion as we move this plan forward. The reason this additional 80 percent is here, the reason the government picks it up really was based on the notion that we have many companies in this country who, because of the very high cost of insurance that they are bearing and continue to bear, have really found their competitive position internationally impaired over time, and this is really meant to be a help to the business community to achieve greater competitiveness, which would benefit all of us.

You see, I may be the person who continues to work, but my job opportunities may actually be improved by the early retirement provision, and that person going into retirement because his company may, in fact, then be able to create more and better jobs through more exports to the rest of the world and come and offer me an even better job than the one I have, so it is not as simple as just giving a handout to a company.

It is what the company, why we are doing that and what the company does with that. I think that is the motivation for why it is here. It is not simply to pick up the 80 percent of someone who is 55-years-old.

Mr. KLECZKA. If we want to give incentives to segments of the business community, why don't we just reduce the corporate tax rate and give it to all, not to only those who are stuck with some very high medical costs because of years of bargaining or whatever the case might be. Your argument looks good, feels good, but it ain't good. We are going to continue the discussion on this, as you probably know, but I come down on the side of—alleviating 80 percent of the employer's responsibility is not something the taxpayers are going to stand for, and I would say that we should at least phase them down from age 55, pay 80, 70, 60 percent until the employer is 65, and at that point the—the employee is 65, at that point—

Chairman STARK. Would the gentleman yield?

Mr. KLECZKA. I would yield.

Chairman STARK. Would then not your argument be quickly and easily extended to those employers who have underfunded their pension liabilities? The only reason we are funding this is they didn't fund it like they should have under good accounting principles.

Now, in the same vein, there is an equally huge unfunded liability for pension funds out there. Your argument holds for that, right?

Ms. TYSON. Well, again, you have to think about how this developed. I think if you look at it, we know that. We have many of our big companies that have been paying huge amounts of health insurance over time.

Chairman STARK. And huge amounts of retirement?

Ms. TYSON. Right. I guess I would leave it the following way. I know that this particular additional 80 percent funding by the government is obviously controversial. In the two other committees I

have talked to this is something that people are very concerned about.

Let me just leave you with the facts, though, in terms of thinking about this. Most of the additional government spending on the 55- to 64-year-olds does not come from the 80 percent. It comes from the fact that one would anticipate more early retirees because they could get insurance at a lower rate and then they will get a subsidy as a worker and they could get a subsidy on their 80 percent as well, and if you didn't have the extra pick up, and you just treated the 55- to 64-year-old who decided to retire as a nonworker, not a special nonworker as these additional pick-up amounts. As a nonworker, the government would be spending money on that nonworking choice.

Chairman STARK. No. Because they could go back. Their employer has an obligation, and most of them are big rich employers from whom you can collect. I mean, make a case that if I worked for General Motors and I have my retirement and I quit at 55, you don't think, if I could get a judgment I couldn't collect? General Electric, for heaven's sakes, has gold-plated, so the case is these are already people for whom this employer is on the hook. He is obligated to pay.

Ms. TYSON. I was really talking about people for whom that was not true, those who would make the decision to go into early retirement.

Chairman STARK. I am intruding. We are intruding on Mr. McCrery's time. I recognize the gentleman.

Mr. KLECZKA. Then I won't reclaim my time, Mr. Chairman.

Chairman STARK. Your time has expired.

Mr. MCCRERY. Thank you, Mr. Chairman. Mr. Tyson, I have to admit, looking at this whole plan and the numbers that you cited, such as the deficit reduction numbers, it appears to be an elaborate scheme to shift public costs to the private sector. That is how it appears to me. Then every time I think I have got this figured out, someone pops up and says, no, that is not right. Certainly, if you achieve the deficit reduction that you plan for, you are either going to get the private sector to pay those costs that the government won't be paying or you are going to have rationing of health care. I don't see any other conclusion. Maybe you can clear it up for me.

It seems that you are going to shift the costs from the public to the private sector. Then I look at the plan, and you are going to limit premiums or the tax increase that is going to cover the cost that the public is going to get out of to 7.9 percent of payroll. So then I say, well, it is going to go back to the public sector because you are going to subsidize that. Then I look and say, well, no, because you cap the subsidies. So you ensure that the public doesn't again pick up those costs. If you do all of that, if you put all of that together, it just seems to me that your plan amounts to rationing of health care. Surely if you increase the universe of people with insurance coverage, which your plan does, you are going to increase utilization of the system. So I just don't understand how all these pieces fit together.

You are going to provide more services and greater utilization of the system. You are going to cut the deficit, and you are going to provide better health care. I just don't understand how that all

computes. It seems to me if you do all the first things, if you reduce the deficit, increase coverage to a greater universe of people, and keep costs down on the system, the only way you can do that is by rationing health care. Under your plan, it seems to me, the rationing decisions are going to be made by the alliances, and you might say by government bureaucrats. That is not real attractive to me, and I submit, to a lot of other people in this country.

Can you disabuse me of this assumption that that is what it amounts to?

Ms. TYSON. There are a lot of parts to your question. First of all, on the issue of shifting from the public to the private sector, it should be clear now that under the current system that also happens, that we have a system where we control Medicare rates, and where we promise Medicaid services that are not funded, and both of those result in a ballooning out or additional spending by the private sector, so a Medicare—

Mr. MCCRERY. Why don't I just interject. You are going to exacerbate that in your plan by offering more services in Medicaid.

Ms. TYSON. No, we are trying to handle that problem by looking at changes in the Medicare and Medicaid program which we believe can be made along with reform of the entire system. There is widespread agreement among many in the Congress that we need to get ahold of health care spending, and people will make proposals for arbitrary caps on the rate of growth of Medicare and Medicaid, not even saying what should be cut as if that is feasible.

That is not feasible because you put on the caps and what will happen is those providers who are capped in the part of the system that is controlled will move or shift the costs of the services into the part of the system which is running as we currently run it. So you identified a problem which we are trying to solve, not trying to make worse. We are trying to solve it by having the system as a whole operate more efficiently.

Now, let me get to your question about rationing, which is I would put it another way as an economist, and I would put it the following way: What has been surprising to me, but I am convinced and what has been sobering to me to realize is how much inefficiency and misallocation we have in one-seventh of our economy right now. I would like to suggest an article to you not written by an economist, but by David Friedman, in The New York Times a couple of weeks ago saying the health care system is the economic outlaw. What he did was he demonstrated, just using a series of anecdotes, all of the pieces of evidence of how the current system has very little competition. It has very little competition.

Consumers have very little choice in the insurance plans that are offered to them. Only 30 percent of employees in firms of 500 or less have any choice at all. So they are basically told this is your insurance system, these are your providers, you don't have a choice. How much information does someone going to the doctor have about the price of the services they are paying or their insurer is paying? Very little information.

How much incentive do providers have to figure out a cost—the least cost way of doing things? Virtually none. It is not that we have a system which is populated by greedy individuals, it is that we have a system where nobody has a market incentive to econo-

mize, so what I have become convinced by is that we have in the system the ability to cover more people, but do it more effectively in a cost-conscious environment with a lot of competition and in the process actually save resources for the Federal Government, but you have to first understand the degree of inefficiency and misallocation that we are currently operating with to appreciate the conclusion, which is, we don't believe that rationing is an outcome here.

We don't believe that is necessary. We believe that the system can actually provide more benefits with the same quality outcome for more people and over time, over time because this is phased in gradually, actually have costs grow more slowly.

Now, I want to emphasize here, this is not a reduction in health care spending. Health care spending goes up in this plan. It does not go down. It just goes up at a slower rate of growth.

Mr. MCCRERY. Yes, we are all familiar with that phenomenon. I hear you. Would you just list for me some of the inefficiencies that you hope to wring out of the system to achieve these fairly substantial savings.

Ms. TYSON. Well, I have actually listed some of them for you in my written testimony. We have a situation in which we have excess administrative costs on the order of \$45 billion a year. We have fraud and abuse of \$80 billion a year. We have a series of studies of organized care of HMO-type care indicating 10 to 20 percent reductions in the cost of the same quality outcomes.

We have studies which show that the same kind of service performed in Miami might be nearly twice as high as a service performed in San Francisco. Both of these cities are very high cost of living cities. The same service is twice as expensive in Miami as in San Francisco. We have evidence that where hospital beds and machines are in excess supply, their prices go up, not down. We have evidence that the availability of hospital beds is correlated with in a community is whether you die in a hospital bed.

People have looked at what the availability of hospital beds is correlated with, and the thing they find correlated is whether you die in one, not whether you are healthier, not whether you get service on time, not whether you are rationed, simply whether you die in one. So there are—we have evidence that if you get preventive care, prenatal care that the cost of the child being in the hospital after birth can be \$2,000 less than the cost of a child who is born to a parent without prenatal care, so if you put all of these things together, and each of them is very dramatic in their own right, certainly dramatic to me, I mean economists start out with a belief that the world is efficient or tends toward efficiency, and when you look at the health care system that we currently have in place that tendency toward efficiency has been blunted by the incentives of the system in which everyone is operating, and if we change the incentives we believe that the efficiencies that are there will be realized.

Mr. MCCRERY. Well, I appreciate your listing those, and I don't think you will find anyone who will disagree that there are inefficiencies in health care. I think you will find a lot of disagreement, though, on the conclusion that a government-run bureaucracy can run the system more efficiently than is being done today, especially

to the tune of the billions and billions of dollars that you anticipate saving with your plan.

Ms. TYSON. Can I emphasize, I really want to make it clear we do not see our system as one of government bureaucracy. We see our system as precisely—

Mr. MCCRERY. I am aware of that, too.

Ms. TYSON. I think it is important—maybe I should turn around. Why would one see it as a system of government bureaucracy? The choices to be made here are choices that providers will make. We are not telling providers what price to charge. We are not telling providers what to do in a given set of circumstances.

Mr. MCCRERY. Well, you are coming very, very close. When you put all of this together, Mr. Tyson, who is going to run this thing? Who is going to decide how to cope with the caps on the subsidies? Who is going to decide what plans are going to get risk adjustment? I just don't understand how all this is going to be done without a huge bureaucracy. The facts just are not very persuasive that a government bureaucracy is going to run anything in this country much less something as complex as the health care system, more efficiently than the private sector, even though there are inefficiencies in the private sector.

Ms. TYSON. What we are trying to do in the reform is to build on what have been very successful but small experiments with market incentives around the country, that we know, for example, that where there have been large pools of people brought together to negotiate for packages, say in California, that they have gotten better prices and cost reductions for the same coverage.

Chairman STARK. Oh excuse me. Are you talking about CALPERS? I just want to mark that.

Mr. MCCRERY. I don't know about CALPERS, but there are some things around the country that do show promise of cutting costs. Mr. Chairman. I agree with Mr. Tyson, but my comment on that would be to give those things some time to work. Let's get some experience with them and see how they work rather than imposing one or two that you think might work on the whole system through government fiat.

Ms. TYSON. I guess I will just conclude by saying I think what we are trying to do is what we have learned from these experiments. One could debate one particular one versus another, but I think what we have learned from the experiments is really two things: One is that pooled groups of individuals negotiating for insurance get better rates. We also see that from the self-insured large companies, that they get better rates.

We also have a sense that oftentimes if people are offered by their employer an HMO situation where they have some cost benefit to themselves personally, that they make that choice, so we are trying to say let's make sure that all consumers have choice so that they don't have one insurance program to choose from, and let's make sure that they are pooled together so that they can negotiate for good prices.

Your sense that it will be a government bureaucracy really gets to your other question really, and it is the question about how you have a vision of our plan as really a plan in which we are operating at the caps. Basically you don't believe the cushions and you don't

believe the efficiencies. You don't see the efficiencies we see. So you really think what will happen is we will phase it in. As soon as we phase it in we are at the caps and it is a managed system.

We believe that on the basis of the numbers that we have and our reading of the system that the premium caps and the capped entitlement on subsidies are really safety valves. I think it is important to have safety valves or backup or emergency brakes in a government plan. I think it is very important for the American people to realize, to recognize that this is a responsible plan that does not allow for the possibility that there would be runaway spending on this program.

Chairman STARK. Mr. Levin.

Mr. LEVIN. I am just struck by those who criticize the proposal, just this recent back and forth, really assume a rate of increasing health care costs that is not sustainable and is a major reason we are addressing health care in the first place. Even if you take away added benefits, they assume that health care costs quickly go through the roof, and so therefore they criticize what happens if there is a roof.

Let me ask you, I missed the earlier discussion about the early retirees, and I know there has been some unease about it. If you would quickly review and lay out briefly the policy reasons for the provision, for that provision being in the proposal.

Ms. TYSON. Well, the case I made was the following: That many of the concerns about the early retiree benefit miss a fundamental point which is that the system of community rating and universal coverage by themselves are a factor which would tend to encourage more early retirement simply because an individual who is currently working solely because they want to maintain their health insurance and looks out there at the rates right now available to a 55- to 64-year-old individual would say I can't retire.

The primary change in the system is that the premium for the 55- to 64-year-old thinking about whether they want to retire or not or move on to another part-time job or whatever, that that premium is so much lower now because of community rating, and the subsidies that would be available for that family, based on income, that it changes the incentives to retire. That is the first point I made.

The second point I made, and it really was debated and my conclusion was that this is something that clearly Congress will have to continue to discuss. Our view was the government picking up the additional 80 percent, which was not the lion's share of what the government would spend on early retirees. The lion's share of what the government would spend on early retirees is just the fact that the early retirees would be nonworkers and be available for nonworker subsidies just like any other nonworker, but the additional special benefits for early retirees were really motivated by the notion of an inducement or a factor that would allow, encourage, and support the restructuring efforts of American companies and that that would lead to the greater competitiveness of the U.S. economy.

Someone asked what will happen to the employed worker who in some sense is paying for this, and what I said is the employed worker may have better job opportunities as a consequence of sav-

ings to the private sector which some of these companies presumably would reinvest to make themselves more competitive and get greater market share abroad, so that is the kind of rationale.

Mr. LEVIN. Is there also the factor of the impact on the competitive, more directly the competitiveness of companies that have large numbers of retirees, of early retirees?

Ms. TYSON. Well, clearly this general benefit for companies would be more important for companies that had large pools of potential or actual early retirees, so clearly to the extent that a company did not have that age distribution, was not currently providing for such benefits, this would not be a particular issue, so it does—I would say it benefits the business community in general, but it benefits more specifically those companies that have those kinds of commitments.

Mr. LEVIN. Where are most of these early retirees? In what kind of former employment?

Ms. TYSON. It is my understanding they would tend to be in large corporations, large multinational corporations, involved in lots of international competition, probably with a unionized workforce.

Mr. LEVIN. Far more industrial than nonindustrial?

Ms. TYSON. Far more manufacturing than not, yes, primarily manufacturing.

Mr. LEVIN. Is that relevant?

Ms. TYSON. Well, it is relevant in the sense that I think this is tied to concerns that have been voiced over the past decade about the competitive disadvantage which a number of important American industries have faced in international competition as a result of the burdens of health care spending on their ability to invest and create jobs, so if you take an American company competing with Japan, an American company competing with Europe, where the health care costs are not nearly as high, where they are operating in a health care system which essentially has made the cost of health care a cost borne by society rather than the individual company, that that has worked to the competitive disadvantage of the American companies. Oftentimes, it has meant lost sales, lost employment.

Mr. LEVIN. One last question. Are there studies about the history of these companies in terms of provision of insurance proportionate to their share of the American economy? In simple English, isn't it true that these larger primarily industrial concerns have carried a disproportionate share of the load of health care in this country?

For example, if you look at coverage for spouses, if you look at the shift from the public to the private sectors, if you just did an analysis, look, we might as well talk about this, we are going to talk about it one way or another, and if there isn't a good policy defense, this will not survive. If there is one, it will, I hope.

Ms. TYSON. The corporate—I did mention that actually not in connection to early retirement, but clearly it is linked as you suggested. One of the things that is the case in the current system is that you have what we refer to as corporate free riding. That is the large unionized companies oftentimes end up paying for the health insurance of the person and their spouse because the spouse is in a service sector job where there is not a provision of insurance, so

essentially what is happening is the manufacturing base has taken on the health care costs of the primary worker and the spouse someplace else, and clearly the reform will improve that situation very much, number one, by reducing cost shifting in general; number two, by eliminating corporate free riding because now the spouse's employer will also have to pay, so I raise it in that regard, but clearly over time that has also been picked up in other kinds of benefits, including retirement benefits.

Mr. LEVIN. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman. I would like to ask you questions along another line, although if I have a chance I do want to follow up on your estimates on the impact of unemployment and also on this issue of retirees.

Would you agree that the economic effects of a fixed cost on a company are different than the economic impact of a variable cost?

Ms. TYSON. Yes.

Mrs. JOHNSON. Would you agree that the majority of Americans are insured through self-insured plans?

Ms. TYSON. Yes, right now.

Mrs. JOHNSON. So in the current situation for most companies in America health care costs are a variable cost.

Ms. TYSON. Yes.

Mrs. JOHNSON. I am concerned about the implications of turning health care costs into a fixed cost because companies have no control over a fixed cost, and so they do not invest to affect it. Because most companies now self-insure, they are motivated to invest in cost control in health care, and indeed most of the creative efforts to control costs have come from the private sector.

You spoke earlier about the lack of competition. That is true at the individual level. Individual people don't choose plans like they will under your proposal, but companies do, and the competition in the arena where they choose their self-insurance and how they are going to manage self-insurance is very intense, and furthermore companies are doing really remarkable things to control costs, and I would call your attention to testimony that we are going to have later, but this is only one of an endless procession of cases where TD industries have cut costs really dramatically by doing things like on-site cancer screenings, on-site flu shots, well-baby programs, prenatal incentives and things like that.

Now, one of the unintended consequences of your proposals that I think is most serious is the effect of changing health care costs from a variable cost to a fixed cost because once you change it to a fixed cost nobody in the private sector will have any incentive to make the capital investment they are currently making in motivating their employees to choose patterns of living that are wellness oriented, to get preventive care, and the entire motivation for that will shift to the public sector by way of premium negotiations.

Now, the public sector's track record in encouraging cost control is, in my estimation, abysmal. Mostly we have been only able to use price controls, global budgets and closed appropriations efforts like the VA system, but we have not even been able to change the Medicare law to make it cover preventive medicine. So we have not been nearly as progressive as the private sector in either preven-

tion or cost control, and I am very concerned about the consequences, and I believe they are genuinely unintended consequences, of what is a far more radical change in our current system than your general verbiage acknowledges.

Changing health care from an employer-based voluntary system to an employer-based involuntary system does change health care costs from a variable cost affected by employer action to a nonvariable fixed cost unaffected by employer action. So all of those millions of private sector cost control efforts will no longer be made nor incentivized nor motivated nor rewarded, and I wonder how you will make up for that and how in light of the government's track record in cost control you can believe that that power shift from the private to the public sector in both responsibility and action for cost control can possibly create the savings that your plan really depends on for its success.

Ms. TYSON. All right, first of all, I want to emphasize that I wouldn't call it—I wouldn't use variable cost and fixed cost precisely the way you use them. It is not a fixed cost.

Mrs. JOHNSON. It is 7.9 percent of payroll, is it not?

Ms. TYSON. First of all, that is a capped cost. Many firms will not be facing that. So one shouldn't think of this as 7.9 percent as payroll, one shouldn't think of this—because some firms will do 7.9 percent of payroll. Some will do 3.5 percent of payroll.

Mrs. JOHNSON. Excuse me just a moment. I think we need to get this clear. The minority will have subsidized premiums, that is 3.5 percent, and someone will pay the difference between 3.5 percent of payroll and the actual premium cost. I think the majority of companies will be at 7.9 percent. Don't you think that is fair to assume?

Ms. TYSON. Actually I can probably find these numbers while I am continuing the question. I can probably give you an estimate of the percentage of firms or workers in the 7.9 percent category, but let me say why that number doesn't actually matter in terms of what I was about to say.

What I was about to say was that firms, remember economists say how does a firm respond to a health care cost, whether it is a mandated cost or a voluntary cost? If you look over long periods of time what happens primarily, not entirely, but primarily, the rate of growth of wages adjusts, so the firm itself has a way to respond that is a variation. The firm looks at its health care costs, looks at its employment decisions, looks at its wage decisions and makes adjustments, so the entire area of labor cost, the number of employees, the wage, and health care is a variable cost component, and firms have flexibility to make decisions within this.

So what I was trying to say in my testimony is, for example, firms that face a lower cost under our plan can decide to offer higher wages. They can decide to hire more people. They can vary things. It is not simply a fixed cost. They can make compensations. A firm that pays the higher cost might actually decide over time to reduce the rate of growth of its wages. It might decide to employ fewer people. It might decide to lower its price, so it is not fixed, it is not—there are things the company can vary. That is my—

Mrs. JOHNSON. But the question I am asking, Mr. Tyson, is a different question. You have addressed that issue before. The question

I am asking is that if health care costs are costs that are no longer affected by the individual actions of individual companies and therefore companies withdraw their capital investment in on-site physicians, on-site nurses, wellness programs, stress management programs, all the things that have enabled some companies to reduce health care costs by 20 and 25 percent, some of the technology that companies have invested in have enabled them to track premiums and reduce workplace-induced illness.

None of that investment will be worth it anymore because they will not, as a company, benefit from it, so they will not make it.

Ms. TYSON. First of all, it is important to emphasize here that most of the experiments you are talking about, as you pointed out yourself, are most effectively developed and extended in large companies. Most of these large companies are—remain self-insured, so they can do——

Mrs. JOHNSON. Excuse me just a minute, on that point two things. First of all, very few companies are going to remain self-insured under your plan.

Ms. TYSON. Some 19 percent of workers are going to remain in self-insured firms, but what I am saying is you are—the most—let me put it another way. Let me really try to answer your question just in a series of points, then you can tell me where I failed, OK?

Mrs. JOHNSON. That is exactly what I am trying to do with you, but we will reverse it for a moment.

Ms. TYSON. The first point is that many of these experiments occur in large self-insured firms. They will remain self-insured, and they can continue with these experiments. For medium and small-sized firms, even ones who experiment, what the current system does is if one of them all of a sudden has a family with a child who gets sick, all of those premium benefits that they realized by all of their experiments can be wiped out. Because they are a price taker, they have no negotiating power with the insurance industry. So we have a situation where firms that have tried very hard to bring down their costs with the most innovative techniques have found that all of a sudden their rates may go up 50 percent.

Mrs. JOHNSON. Mr. Tyson, I agree with that exactly. Just a moment. Other plans that are on the table will give those small firms the purchasing power you recognize that they need, but as to your statement that most of the companies will stay self-insured that are currently self-insured, your plan requires their employees to individually participate, and that company will not stay self-insured because the company will not be a participant. Only the employees.

The company will face only a fixed cost over which they will have no control. The fixed cost will be determined by the negotiations between the health alliance and the few large insurance companies that will be in the market, but the employer, as such, will be the recipient of a fixed payroll percent that they will be obliged to pay, so to imply that it is in any way similar to the situation of self-insured companies where their own investment and actions can reduce their health care costs is to mislead.

Ms. TYSON. But you misrepresented what I said.

Mrs. JOHNSON. OK, let's get to it because I don't think I am.

Ms. TYSON. You made a statement about what I said, and I didn't say that. What you said was that a number of large compa-

nies have done many very innovative experiments and have succeeded in bringing their costs down. I agree with that. I pointed out that some of the most successful of these, where the negotiating power has been the greatest for a company to bring down its rates on the basis of a very extensive preventive care program, those companies tend to be very large employers. They are the companies—

Mrs. JOHNSON. Excuse me just a minute. Let's stop right there just a minute. You are saying—your plan only allows someone to be out from under the plan if it has 5,000 employees. Now, the companies I am talking about who have done these wellness things have 250 employees, 500 employees.

Ms. TYSON. But I was trying to answer—first, I was saying that some of the companies that you are concerned about will be out. They will be self-insured. Now, let's go to the 250 employee firm.

Mrs. JOHNSON. Do you agree with me that the only companies that will be out are the companies over 5,000 employees?

Ms. TYSON. I am not trying to mislead you. The plan says clearly—

Mrs. JOHNSON. I think it is important, Mr. Tyson, to recognize that there are very few of those. In the State of Connecticut there is maybe a handful. Second, they will be forced to provide a locally based system and they also will pay penalties if they stay out of the system, so my belief is that of the handful that could stay out, none will because they will be penalized for staying out in a number of ways by your plan, but they aren't the ordinary. They are not going to be 90 percent of the people in Connecticut, so for 90 percent of the people in Connecticut—

Ms. TYSON. I certainly did not imply that.

Mrs. JOHNSON. For 90 percent of the people in Connecticut the employers will have no impact on their health care costs. Is that not a fair statement?

Ms. TYSON. Let me turn it around and ask you—

Mrs. JOHNSON. Would you just answer, yes or no, first?

Ms. TYSON. I actually lost track of the question because—

Mrs. JOHNSON. The question is this: For any employer who has fewer than 5,000 employees—

Ms. TYSON. They are in the alliance.

Mrs. JOHNSON. They are in the alliance, their health care costs will be a fixed percent of payroll.

Ms. TYSON. No, their health care costs will not be a fixed percent of payroll.

Mrs. JOHNSON. Why not?

Ms. TYSON. It depends on whether they are capped or not. Sixty-five percent of the firms will not be capped. They are not—we don't know, we don't have them capped, all right? So they are not capped, so you can't think of this as—

Mrs. JOHNSON. That isn't the point.

Ms. TYSON. It is the point. You said it will be a fixed percent of payroll. That is not right.

Mrs. JOHNSON. That is right, so whether that percent of payroll is 7.9 percent or 6.5 percent or 3.35 percent.

Ms. TYSON. It is not fixed.

Mrs. JOHNSON. But it will be a percent of payroll over which their actions will have no control.

Ms. TYSON. The better way—

Mrs. JOHNSON. This is an incredible misunderstanding.

Chairman STARK. Perhaps this could be worked out if there is a misunderstanding.

Mrs. JOHNSON. Let me just conclude on that point, Mr. Chairman.

Chairman STARK. I think your time has expired.

Mrs. JOHNSON. But this is such a major issue that we shouldn't misunderstand it.

Chairman STARK. If it is so major, you may come back to it. Mr. Coyne wanted to inquire. If not, I was going to inquire. And just to get off on a couple of issues, I would like to go back. Paul Samuelson had to bear me as a cross all these years since my undergraduate days, so bear with me.

Competition and incentives to economize. In the economic world according to Ira Magaziner and those at higher altitudes, we talk about plans, and you mentioned some earlier in your testimony. We have examples. Do you want to go back for me and explain where you think we have examples of competition working? I think you were referring to CALPERS.

Ms. TYSON. I have not looked at all these examples in detail. I can list them for you, but I could not give you—

Chairman STARK. CALPERS for the previous 9 years has never been below a 10 percent rate of increase in their premiums, and it was only last year when Governor Wilson was on the shorts that they cut back. Kaiser said that the only way they cut back was by reducing benefits, and, in fact, until this year any cuts in premiums were accomplished by the plans in CALPERS through reducing benefits to employees.

Would that be a very good example over any period of time of what we are talking about?

Ms. TYSON. If that is all the case, and I certainly don't know it in detail, that would not be a good example.

Chairman STARK. It is. What I am going to challenge you with, Doctor, is that we don't know in this country of a plan where these competitive bidding pools have produced any savings over any period of time. Occasionally, where you pick up a group on a one-time savings to capitate them, say, after that first year the rate of increase just goes right along with everybody else, and admittedly if we could lower the access for the whole country, we would save some money for a while, but that is not what we are trying to achieve, so I only say that I don't think, and I would welcome empirical examples, that we have any experience in this country with competitive models on which we ought to risk this plan's efficacy because we are treading on thin ice there.

I just bring that up. I will give you my test on this. You won't be the first, but you are in the Federal Employee Health Benefit plan?

Ms. TYSON. Yes.

Chairman STARK. Do you know how much is taken out of your check each month for the plan you pick?

Ms. TYSON. I don't remember.

Chairman STARK. Do you know whether it is 80 percent of your hospital benefits or 75 percent, and if you make a phone call, do you——

Ms. TYSON. I do know that because I chose a high option plan.

Chairman STARK. How many days of mental health care?

Ms. TYSON. I don't know that.

Chairman STARK. What I guess I am saying, and don't be embarrassed, none of us do.

Ms. TYSON. I think that is part of the way the current system works.

Chairman STARK. We don't care. We pick the plan, we read the book, we picked the plan, we are healthy, we don't anticipate——

Ms. TYSON. But the difference is, I think it is important to emphasize the difference is that as a Federal employee, I do have a choice.

Chairman STARK. Yes.

Ms. TYSON. And that is very important. I do not remember the specifics anymore, but I actually did sit down and at great length late in the evenings since it was early on in the administration read through these plans and try to make sense of them, and I made a choice of one. Most people don't have that choice, so one of the reasons why we——

Chairman STARK. Most people in a corporation don't have as extensive a choice, but they have a choice. They have a fee-for-service plan, or Blue Cross and sometimes even more.

Ms. TYSON. You have basically a situation where in firms of 500 or less only 30 percent of the people have choice right now.

Chairman STARK. That means 70 percent have a choice. Let's put it the other way. That isn't shabby.

Ms. TYSON. No, only 30 percent have a choice, 70 percent don't.

Chairman STARK. When you talk about elasticity and all those things, there is nothing in health care that suggests that the competitive model will work.

Maybe premiums we can understand as well as the copays. We can function with that. But most of us don't know the difference between a horoscope and a proctoscope and whether we will need it, and actually sometimes the doctors don't know. If you come to a doctor and they send you for a test, most of the doctors don't know what the test is going to cost unless they happen to own the facility, and we are dealing with a system, and I am not sure it is very important, quite frankly.

The rest of the world, the industrialized world, say South Africa, doesn't do it, and they get along better than we do. We have had the competitive model since 1981 or 1982 when we defeated cost containment, and what has it brought? In the Bay Area we have it in California, as close as you are going to get, probably 70 percent of the people in Alameda County are in some kind of managed care plan, and the costs there are going through the roof. There is no indication that there are any——

Ms. TYSON. Of course, it is harder. You could imagine that managed care plans in an overall environment where there aren't many may actually be quite constrained in their ability to achieve cost savings precisely because if there are other parts of the system

that are running at high cost and the HMOs are connected into the other parts of the system, they can't—

Chairman STARK. Do you know the one system that has the lowest rate of increase in hospital and doctor costs in the country?

Ms. TYSON. No.

Chairman STARK. Medicare. Less than half the rate of increase on the physicians. Now it shifts to the rest of the—

Ms. TYSON. It shifts.

Chairman STARK. But if you put the same constraints on the private side you would have it in a box, wouldn't you?

Ms. TYSON. I think at that point really we have to ask ourselves, we are really into a different level of—really into a very different design at that point because basically you are into a design where then the government, in fact, does set the prices of services.

Chairman STARK. But wait a minute. There is such a little difference between how the prices are set in these two plans. Let's stop for a minute. Medicare sets fee-for-service rates through negotiation, right? And the DRGs and the doctors' rates, OK. So does the President's plan, set fee-for-service and hospital rates on that side, if you choose a fee-for-service?

It is just a question of whether you do it in the State or whether we do it through PhysPRC and ProPac. Identical.

The President's plan sets premium rates, right? So does Medicare for the risk contracts. If you choose under Medicare to go into an HMO, we set the premium rate. No difference. The question is who sets it? Do you set it at the national level?

In Maryland they set the hospital rates at the State level because we give them authority. So I am not suggesting there is any great difference there, but I am suggesting that in the Medicare plan we have 28 years of statistics and figures and information on which to build a model, and we seem to be throwing that away and saying let's go off into the ether somewhere at about 9,000 feet where the oxygen is thinner. I don't know whether it will work or not, but I am more comfortable when I can deal with actual enterprises or institutions.

Ms. TYSON. Could I just say that I think we are—in either direction we are dealing with a big enough change in the system, whether we went forward on a Medicare-based system or with our plan. In either situation we are dealing with a big enough change in the system so that there will be uncertainty.

It is very hard, it would seem to me, to predict how taking the Medicare system and extending it to the entire population would work because how it worked in the past depended very much on having most of the system out of Medicare, so that providers and hospitals could make adjustments to the Medicare rates by adjustments in the non-Medicare part of the system.

The other thing we know from the Medicare experience is that it becomes an effort of continually controlling not just the price but the volume or intensity of what is done because we know the providers have not only responded to rates by moving into—by changing how they deal with the rest of the system, but they have also responded by changes in the intensity of the services they offer, so there is a lot of uncertainty in moving forward with that system.

What our position, our starting position was, was that we wanted to build on the best of what we had in place. Since 9 out of every 10 Americans is currently covered by their employer, since we do know, as Mrs. Johnson pointed out importantly, we do know that companies have been able to find ways to bring down costs under competition, but not all of them can.

Chairman STARK. Not according to CBO. We don't know that.

Ms. TYSON. Here is what I am saying. We can pick out individual companies who have been able to do that. The problem is the system doesn't allow the individual company experience to be broadened, so that a company of 250 that brings its own costs down, that particular experience, first of all, as I pointed out, can be undone overnight by the insurance industry if somebody in the firm gets sick, also maybe the only reason the insurance industry is giving the good rates is not because of their preventive care, it is because they have young workers, so they are giving them a noncommunity rate.

Chairman STARK. There is no empirical evidence that companies who have managed their health care costs have saved money according to the GAO. There is a lot of feeling that they are withholding care and making changes, but there is darn little evidence. They finally got the CALPERS number, and according to Lewin from 1982 to 1992 they averaged 12.9 percent as opposed to the rest of the country, which was somewhat lower. Really not a very good record. Good plan but not a good record.

There are a lot of reasons. I mean, sick people join fee-for-service plans. You know the answer. All I am suggesting, we have in the President's plan a plan to dismantle Medicare. It is very clear. If it is in there, you have heard it privately stated by the inside wonks that this is what they would like to do over 5 years.

They tried to put it out front in the plan, but it is a formula for disbanding Medicare. That may be something we should look at when we know there is a system to replace it, but it works. Medicare works very well, better than any other insurance system in the country for the seniors. It has just always seemed to me rather capricious to say let's take all of this away. Actually let's do away with the private insurance structure as we know it, and replace it with a system wherein we have no experience. That is a leap of faith that I am having trouble making. I am willing to approach it, but I have a little problem.

Finally, I thought I heard you mention in your exchange with Mr. McCrery that we were going to recapture 50 percent of corporation's retiree health benefits.

Ms. TYSON. Of the first 3 year benefits of the early retirement.

Chairman STARK. Now you are saying it right. The administration has been saying 50 percent of the benefit to the company, and you and I know that is not correct, don't we?

Ms. TYSON. I am not sure that what I—I—you better tell me what you think it is and I will tell you what I think it is.

Chairman STARK. All right. You have said it correctly. I have heard the administration saying not to worry about giving this benefit to General Motors, General Electric. We are going to recapture 50 percent of the savings, but you just said it properly. We are going to recapture 50 percent of the first 3 years savings, and

think we both recognize that there is on balance a 10-year obligation.

Ms. TYSON. Right.

Chairman STARK. And that therefore the savings at best, even on an average is 31, if in fact it runs to 10 years, we are talking 15 percent recapture, and as I say, it is like we were selling long-term care as a Medicare benefit. It is a good plan actually, but we don't have to fudge the numbers. It is like saying it is not going to be a tax, it will be a mandated premium.

Well, I will get on the message, as they say in your office, but my colleagues here are going to tip off my opponent back in San Leandro and say that is a tax because Stark is making you pay it. I don't much care, and I suspect that you don't, either.

From an economist's standpoint does it make any difference if the same employer relative to the same employees pays a tax for the amount or a premium for the amount? Does it have any effect on the job or the economy?

Ms. TYSON. I think that to treat this as a tax would be absolutely inconsistent. There are other—

Chairman STARK. I am just saying does it make any difference to the number of jobs?

Ms. TYSON. It would make a difference in the sense that once we—if we start with the notion that this particular mandate is a tax. First of all, what we would do here is we would take all of the billions of dollars which companies are currently paying, and we would call it a tax because to do it right you would have to take every dollar of premium currently being paid.

Chairman STARK. But you are mandating it from now on.

Ms. TYSON. Do you really want to say that we have gone from—

Chairman STARK. What difference does it make?

Ms. TYSON. It makes a tremendous difference in terms of, I think—

Chairman STARK. Politics?

Ms. TYSON. In terms of how it appears in the Federal budget, in terms of accounting rules of the government.

Chairman STARK. That is politics, but what difference will it make to the jobs?

Ms. TYSON. It is not politics if you—

Chairman STARK. What difference will it make to the jobs in any of our districts? It is the same dollars collected at the same period of time with the same relationship.

Ms. TYSON. There are studies which suggest that taxes have psychological effects as well as they have economic effects, and a premium has one psychological effect and a tax—so one day you are paying a premium and feel good about it and you chose to do it.

Chairman STARK. Mr. McDermott is a psychiatrist, and we will have to cede, you and me to Mr. McDermott for the psychological impact of taxes.

Ms. TYSON. I was being serious in the sense that there is a serious point of view in economics that in thinking about the effects of something that it may be that there is an effect of calling it a tax, but my serious argument would be that we have rules which

exist already for determining whether or not something is called tax.

To call premium payments that are currently being made voluntarily a tax would be totally at odds with our current accounting. We have to redo the entire Federal budget.

Chairman STARK. When they are mandated there is a real rise and we won't know that answer for a while.

Ms. TYSON. Do we get to say, then, as the rate of growth of premiums go down over time as a result of our reform, we get to say that is a tax cut, I hope?

Mr. THOMAS. That is a deal.

Ms. TYSON. I think it is basically——

Mr. THOMAS. We are in agreement. If you go down you can call it a tax reduction.

Ms. TYSON. My answer is that it is inconsistent with the way that we currently evaluate what is a tax and what is not a tax. There are many mandates out there. None of them are called taxes.

Chairman STARK. I will stipulate to that.

Ms. TYSON. It does not specify a particular rate. It specifies that you must make a payment. The payment will vary by region. It will vary by——

Chairman STARK. It caps.

Ms. TYSON. It depends on where you are capped, if you are capped at all, the actual amount you pay depends on decisions you can make such as varying the amount of people you employ or varying your output level. You have ways to respond to this so I think it would be inappropriate to call it a tax.

Chairman STARK. OK. But I didn't hear you say that it would make a determinable difference in job loss or job creation or the economic impact in general. If the stream of dollars is the same, what we call it doesn't have an economic impact—except for that——

Ms. TYSON. If the stream of dollars——

Chairman STARK. Except for the tertiary psychological effect.

Ms. TYSON. If the stream of dollars were the same it wouldn't change the economic effect. It might very well change the prospect for passage, but that is a political and not an economic issue, and I am here to discuss economic issues.

Chairman STARK. I understand, and I am just suggesting that in selling the plan sometimes you make it more difficult for us. The Freemont Rotary Club may not have had the advantage of Paul Samuelson, but, boy, if they start in on me and get me at the podium and you only get 20 minutes there and then they shut you off because they all have to go back to work.

Ms. TYSON. It seems to me the issue for the Freemont Rotary Club finally is not what you call it, the issue for the Freemont Rotary Club is making sure that the members of the Freemont Rotary Club understand that contrary to what they are sometimes reading and hearing, many of them will immediately pay less for even better benefits for their employees, that some of them who would love to buy insurance but can't will now be able to buy it.

Chairman STARK. Doctor, you are looking at the original snake oil salesman who tried to sell the senior citizens on that theory some years back. I thought my legislative legerdemain was insur-

sible. And it was a good bill. It only lasted a year. And there are a lot of us still licking our wounds from that.

That is a why question that remains to be seen. But I think I learned my lesson. I would just as soon say to the folks who want to call it a tax, a tax. You still have to pay it. But it is still a bargain. I mean, this is political philosophy. I can defend it either way. It doesn't matter whether it is a mandatory premium or a tax. It is still right to do.

And this idea that if we try to shrink from it as we play into the hands of the Ross Perots of the world and the Rush Limbaughs who will tell everybody in the world that we are trying to disguise something, I mean the plan is right. That is the key. People should pay. That is the key. The amount is minimal. That is the key. What you call it is a matter of indifference. I am sorry. I interrupted my colleagues here. I am sorry.

Would anybody else like to inquire? Mrs. Johnson.

Mrs. JOHNSON. I am going to move on to the second subject that I was interested in. But I think just to comment on the discussion that has preceded, it is more than a psychological difference as to whether it is a tax or a premium. And that is the point I was trying to make on the issue of fixed versus variable costs.

I want health care costs to continue to be affected by the millions of inventive and creative minds that have made our private sector the strongest, most productive sector in the world. And I think by changing it to a fixed cost over which individual employers have no control, you are disconnecting the brightest minds in America from the subject of cost control, but I want to look at your estimates of job loss.

Now, your bill requires that health care spending decline so that in the second year, it is GDP plus 1.5 percent, then GDP plus 1 percent, then GDP plus .5 percent; is that correct?

Ms. TYSON. I have actually not seen the precise numbers with the recent trust, but that is approximately right.

Mrs. JOHNSON. I haven't read it in the recent draft either.

Ms. TYSON. From the point of view of estimating employment effects, these numbers have not changed at all relative to the macro effect.

Mrs. JOHNSON. No country in the world has succeeded in lowering any health care costs to any of those three rates for a multiyear period, so the likelihood that we will be able to get down to GDP 1 percent or .5 percent is practically zero in my mind.

But that is why many of us think a global budget is going to be a backstop. It is going to be a company leader. A primary force. In addition, your legislation specifically requires the premium base to fund not only the health care costs of the people covered and the administrative costs of the insurer, but 2 percent will cover the administrative cost of the health alliance, an additional 2 percent will be added in.

Now, we are up to 4 percent of premium to cover nonpayment of premiums by other participants and other such costs. Other percentages will be added in to fund medical education. And there is a series of other percentages. So about 6 or 8 percent of the premium will now go to cover costs not currently covered by premiums.

So not only will you have the premiums set in the context of a pace of health care spending decline that we have never experienced, but in addition, those premiums will have to cover a lot more things.

The net result will be that very much less money will be available to cover health care actions. Now, I understand that it is your hope that the consequence of that will be that those surgeons who charge less for heart operations will be the ones who do the heart operations, and that those hospitals that have a lower cost per room will be the ones where the patients will go. And I am keenly aware of the problems within our provider sector.

But there is no evidence that the system can respond in the time frame that you are asking it to, in the way that you wish. And, so, it is far more likely that, for example, in a State like Connecticut where there are at least 11 CAT scan machines, that some of those will simply be closed down. That may be good. That may be bad. But I believe at the pace of spending cuts that are anticipated, it is inevitable. I am not sure it is defensible to have 11.

Quality of care is not the issue. But certainly by eliminating half of the CAT scans in Connecticut, we will eliminate also now the complex of employees that support them. They are well-paying jobs. They are highly technical jobs. If you eliminate tests at the pace that this is going to require their elimination, whether they are needed or unneeded, you will certainly drastically down size the size of that sector that does that kind of work.

So when I look at the precipitous cut in spending you are proposing, coupled with the even steeper decline, which lies behind it because the amount of premium money that is going to be diverted to fund other things than health care costs, then I would have to say that we are going to reduce precipitously the volume of health care we are going to purchase.

And that has to have an impact on employment that you are not taking into account or you are not acknowledging because your figures don't make sense in terms of the practical world where I see it all happening.

Ms. TYSON. First of all, on the issue of the growth rate of spending, I want to make two points. The first point is that while most other countries have not seen growth rates as low as the one we predict by the end, they also are not at the same starting point as the United States. We are clearly an outlier.

We spend much more of our GDP on health care than any other country, and we have a much larger pool of uninsured, and we have health care problems like infant mortality and life expectancy measures which suggest, if you just look at those numbers, that we are the outlier.

Mrs. JOHNSON. But we are also the outlier in terms of quality.

Ms. TYSON. We are the outlier in terms of quality for some. And we are the outlier in terms of lack of coverage for others.

Mrs. JOHNSON. Like we are the outlier in teen pregnancy and violence—

Ms. TYSON. You suggested that we were trying to do something which no other country has done. And I am suggesting we are starting from a place where no other country is.

The reason we believe that we can do this without the deleterious effects on health, which you imply in your comments, is because of all of the reasons I suggested before, I think to Mr. McCrery, about inefficiencies and misallocation and excess of supply in the current system. If we didn't believe that, then clearly we would have presented different numbers to you.

Mrs. JOHNSON. Mr. Tyson, I guess—

Ms. TYSON. There are health care experts around the country who support our notion of how much can be saved. It is not a fantasy.

Mrs. JOHNSON. Mr. Tyson, I know you believe that, and you also have some reason to believe it, but you don't have either numbers or policies, because I have asked preceding administration witnesses for the strategies that you plan to implement that will assure that the cuts will be taken where you hope—where you think they should be taken, for instance, in the fact that we are an outlier in low birth rate babies is not going to be affected by your plan. You are not addressing that.

The fact that we are an outlier in violence and therefore emergency room costs is not going to be affected by your plan. My plan doesn't address those things either. We can't address those things through health care costs, but if those costs don't decline, then all of your cost savings have to come out of redundancy for that group that is most legitimately sick and also carrying the economic cost of the plan.

And you have so far shown me no numbers, no hard fact that shows that your plan is going to result in savings in the area where we all know some savings can be generated, certainly. But I think it doesn't compare to the savings that can be generated in the other areas and by some other aspects of the plan.

Ms. TYSON. What the numbers do show is that you can achieve the gradual reduction in growth rates of spending that we predict. You can easily achieve that reduction on the basis of inefficiencies in the current system.

Mrs. JOHNSON. Those are the numbers you haven't given me. You say it is easily achievable. They are precipitous cuts. As one who has sat on the Medicare subcommittee and who has seen how very hard it is to cut \$2 billion out of a \$14 billion increase, I can tell you there is nothing easily achievable about the reductions that you are proposing.

Ms. TYSON. What I meant was that there are sets of numbers that we can provide to you which the Health Care Task Force has put together, I didn't bring them with me, showing the amounts that can be saved from administration, inappropriate procedures, on extending HMOs—assuming that HMOs extend on a voluntary basis—that show that there are a number of ways that can you add up those numbers, and then you can say—

Mrs. JOHNSON. My light has gone on and I don't want to—but those numbers are ones which we have to—

Chairman STARK. The numbers, she is right, we have not received them yet. I am not sure, on behalf of Mr. Tyson, that she was here more to talk to us about job loss in the economy and she has done yeoman's work in defending the entire plan from every direction, and she is entitled also to the Chair's apology for munch-

ing his soup while she has gone way past lunch and is probably starving.

And so I am going to intrude where I should have intruded an hour ago and say thank you very much. You have been kind and generous with your time. It has been helpful. We are going to have a lot of discussion over the next year as we wind through this and we deeply appreciate your consideration today.

Ms. TYSON. And let me say if there are some follow-up questions, we could try to prepare some written material, for example, on the issue of how many firms are capped and not capped. That might be useful. We have looked at this number and we can give you a breakdown of firms in terms of where they appear. It might be helpful.

Chairman STARK. Thank you.

Mr. THOMAS. Thank you very much.

Chairman STARK. Our next witnesses are a panel of economists, and I would like to welcome Jacob Klerman, an economist with the RAND Corp., and Martin Feldstein, president of the National Bureau of Economic Research and a professor of economics at Harvard University.

Gentlemen, it is good to see you with us. Mr. Feldstein, it is good to have you back.

Welcome to the committee. Let's see, Mr. Klerman, you are up first.

STATEMENT OF JACOB ALEX KLERMAN, ECONOMIST, RAND CORP., SANTA MONICA, CALIF.

Mr. KLERMAN. Thank you.

My name is Jacob Alex Klerman. I am an economist with RAND, a nonprofit public policy research institute in Santa Monica, Calif. I am testifying on behalf of myself and my colleague at RAND, Dana Goldman. This testimony draws on our ongoing research at RAND. It does not necessarily represent the position of RAND or its sponsors.

It is both an honor and a pleasure to be here today to testify about our joint work on the magnitude of the job loss likely to occur as a result of the proposed Health Security Act. We have prepared a written statement describing our analysis in detail and we ask that it be entered directly into the record. Before the committee, I will briefly summarize the analysis. I will then be happy to answer any questions you might have.

The country is now engaged in a great debate over health care reform. Many valid and important arguments have and will be made concerning the details of the President's plan and those of alternative plans. Among those arguments has been a prediction that health care reform will lead to the loss of several million jobs. We believe that such estimates are incorrect. Our best estimate of the direct job loss due to health care reform is under one-half of 1 percent of total employment, so that direct job losses need not be a major consideration in the evaluation of the Health Security Act.

Let me explain how we arrive at our estimate. The fundamental question in evaluating the likely employment effects of health care reform is who will really pay for the mandated health insurance. Nominally, the President's plan requires employers to pay 80 per-

cent of the required premiums. In response to such a mandate, employers can pursue some combination of four actions.

First, a firm can do nothing, in which case labor costs will rise and profits will be lower. Second, the firm can raise the prices it charges for its products. Third, the firm can lower wages. Fourth, the firm can reduce employment, possibly through attrition.

As we discuss in detail in our written statement, recent research on the incidence of mandated benefits suggests that most, if not all, of the increased labor costs—net of any government subsidies—will be passed on to workers in the form of lower wages. If so, employers' total labor costs will not rise significantly and they will have little reason to reduce employment.

The administration has frequently noted that the earnings of American workers would be considerably higher if health care costs had increased only at the general rate of inflation; that is, if employers had not had to pay the higher health insurance premiums, they would have raised wages \$1,000 since 1975. The converse of that position is that if we require firms to provide health insurance, they will lower wages over the intermediate term. While lower wages for some workers are a potential disadvantage of the Health Security Act, this effect will be mitigated by subsidies. It is this assumption that workers themselves will pay for much of the health care in the form of lower wages which yields our lower employment effects.

This observation, that employers will pass on the cost of the insurance premium to workers in the form of lower wages, breaks down for low-income workers. The Fair Labor Standards Act, the minimum wage law, prevents most employers from paying their employees less than \$4.25 an hour. For workers whose current earnings are less than the sum of the minimum wage and the cost to the firm of the health insurance benefit, health care reform effectively raises minimum compensation. In this sense, it will have effects analogous to an increase in the minimum wage.

There is a large literature on the effects of the minimum wage. That literature has recently been updated to reflect the 1990 and 1991 changes in the Federal statutory minimum wage. Contrary to the expectations of most economists and basic textbook theory, case studies of the recent increases fail to find any employment loss due to the increase in the minimum. Econometric studies over longer time periods attribute measurable, but small job losses to changes in the minimum.

Putting together these two sets of assumptions first, the shifting of costs to employees and second, the analogy to an increase in the minimum wage, our best estimate of the effects of employment losses due to health care reform is considerably less than one-half of 1 percent of employment.

Our lower estimates of job loss rely fundamentally on our assumption that wages are flexible downward, so that employers will be able to pass on the cost of the mandated health insurance to workers. Experience in the American economy over the last fifteen years suggests that there is considerable downward flexibility in wages over the intermediate term.

The magnitude of actual job losses are likely to be quite sensitive to the details of the final health care reform legislation. Which

firms will be eligible for the subsidies? How large are they? Will they be phased out? How fast? What restrictions will be put on the ability of firms to outsource?

Among the crucial details, it is important to note that under the Health Security Act, the subsidies go to firms with low average payrolls. A firm with a high average payroll that considers hiring a worker at the minimum wage will pay the full premium, considerably increasing employment costs, and giving the firm an incentive to outsource that work or to not hire the low-wage worker.

In our work, we have deliberately considered only employment effects due to firms laying off workers as a result of the requirement that they contribute toward their employee's health insurance. If health care reform succeeds in its goal of significantly lowering health care cost inflation over the intermediate future, it would have positive effects on the economy as a whole which would be likely to include higher wages and higher employment. Our estimates do not consider such effects.

In addition, the legislation is likely to have two effects that will induce workers to be less inclined to work. First, health insurance will be guaranteed for both workers and nonworkers. Thus, it will not be necessary to work in order to get health insurance. Second, if individuals do work, their wages will be lower because employers will have allocated some of their compensation to cover the cost of their health insurance. Therefore, we will probably see fewer people working; and these decreases are likely to be concentrated among low-income workers (mostly young people) and among early retirees. On the other hand, these same reforms are likely to increase job mobility by eliminating the link between a particular employer and insurance, and may increase the desirability of low wage jobs to welfare recipients by allowing them to keep their health insurance.

Finally, we would like to note that the magnitude of the changes involved in a reorganization of a major sector of the economy lead us to treat our estimates as informed guesses; unexpected consequences seem possible, if not likely. Nevertheless, our estimates are for reasons discussed in detail in our written testimony considerably lower than many that have been widely cited by opponents of the Health Security Act. We believe that they represent best estimates at the present time; they imply that significant job losses need not be a major concern in your evaluation of the President's plan and alternatives.

That ends my oral comments. I would be happy to answer any questions.

Chairman STARK. Did you ever think of a second career as a traffic reporter for a radio station? You sure read that fast.

[The prepared statement follows.]

STATEMENT OF JACOB ALEX KLERMAN AND DANA GOLDMAN RAND CORPORATION

With the release of the proposed Health Security Act, the great debate about health care reform in the United States has entered a new phase. The fundamental issues in the debate involve how much health care should be guaranteed to which Americans, the role of government in the reformed health care system, and who will pay the additional costs of extending health insurance to the currently uninsured¹.

Like other proposals, President Clinton's plan would extend the current employment-based financing of health insurance. The plan would require employers to pay 80 percent of the health care costs for each of their employees. The required plans are not inexpensive; the President's plan will cost approximately \$1,800 per year for an individual policy and \$4,200 for a two-parent family policy.² Average annual earnings in the United States are approximately \$24,500, and a full-time employee working at the minimum wage only earns \$8,840 annually. Thus in the absence of subsidies, employer contributions towards health insurance for an individual earning the minimum wage would constitute 16 percent of a single worker's earnings ($80\% \times \$1,800 / \$8,840$), and 38 percent of earnings for a worker in a two-parent family ($80\% \times \$4,200 / \$8,840$).³ For an individual with average earnings, projected premiums still constitute 5 percent of earnings for a single earner and 14 percent for earners in a two-parent family. Thus, health care reform may substantially increase labor costs for employers not currently offering health insurance.⁴

In a period in which employers have already pared employment and company balance sheets are lean, many policy makers and researchers are concerned about the potentially adverse effects of these cost increases on employment. A widely cited report by June O'Neill and Dave O'Neill, "The Impact of Health Insurance Mandate on Labor Costs and Employment" for the Employment Policies Institute, projects that health care reform would result in 3.1 million lost jobs.⁵ In this testimony, we attempt to outline what is known about the likely employment effects of requiring employers to pay 80 percent of the health insurance costs of each of their employees.

The paper proceeds as follows. In the next section, we consider how an employer mandate might affect firm behavior. There we discuss recent research which finds that when government requires employers to provide benefits to employees, most of the cost is shifted to employees in the form of lower wages. We also note that for workers with very low hourly wages, it is illegal for firms to lower their wages enough to completely shift the cost of the employer contribution to employees. For employers of such low-wage workers, the mandate effectively becomes an increase in the minimum wage. We then discuss recent research on the employment effects of increasing the minimum wage.

In the second section, we discuss the methodology and results of the O'Neill and O'Neill study. For several reasons, we conclude that their estimates overstate the number of jobs lost. In the third section, we use the recent evaluations of the minimum wage and new tabulations of the characteristics of the uninsured from the 1990 Survey of Income and Program Participation to derive our own simple aggregate estimates of the likely employment effects of the Health Security Act as it is currently formulated. The paper concludes with a summary of the key policy issues, as well as a discussion of details of the final legislation that would cause significant shifts in our estimates of employment effects.

1. The Employer's Perspective

1.1. The Employer's Choices

To provide perspective, it is useful to consider the choices facing a firm that does not currently offer health insurance. After health care reform passes, such a firm will pursue some combination of four actions.

- First, the firm can absorb the increased labor costs, in which case the new mandate will result in *lower profits*.
- Second, the firm could *raise the prices* it charges for its products. In so far as the firm's competitors also do not currently offer health insurance, their labor costs will also increase. Thus, while an employer may feel there is no leeway to raise prices now, doing so may be easier in the context of health care reform. If this occurs, consumers bear the burden of the mandate through higher prices.

- Third, the firm can *reduce workers' wages* so that its hourly labor cost remains unchanged after a transition period. Since earnings usually increase with job tenure, over the intermediate term firms need not actually reduce the wages of any current employee. Firms could simply forgo wage increases, or keep them below the rate that would have prevailed in the absence of health care reform.⁶ This strategy may be particularly appealing to employers for young, low-wage workers. Evidence suggests that the median wage increase for workers starting at the minimum wage is 20 percent after the first year (Smith and Vavrichuk, 1992). In addition, low-wage and uninsured jobs have considerably higher job turnover than insured jobs, so firms could explicitly lower wages as new hires replace departing workers (Klerman, Buchanan and Leibowitz, 1992).
- Fourth, the firm can *reduce employment* (possibly through attrition) of workers who do not warrant the increased compensation.

1.2. Who Pays for an Employer Mandate?

Recent experience with other employee benefit mandates suggests much of the increased costs to firms will be passed on to workers in the form of lower wages. Gruber and Krueger (1990) examine workers' compensation insurance. Worker's compensation insurance premiums vary widely across states and across time periods. Comparing changes in wages with changes in insurance premiums (for high-risk occupations where the premiums are large), they find that firms passed on approximately 85 percent of the increase in workers' compensation costs to employees in the form of lower wages. In other words, for every \$10 increase in worker's compensation premium, employee paychecks were reduced by \$8.50. Because of this backward-shifting onto wages, they find little evidence of a significant decrease in employment.

Gruber (1992) explores the effect of state requirements that firms offering health insurance cover childbirth. In the 1970s, several states passed such legislation, and then in 1978 the federal government passed a national requirement. Gruber studies the relative changes in earnings for women of childbearing age before and after the legislation passed, across states which did and did not pass such legislation. He finds that essentially all of the increase in costs per female of childbearing age (between \$250 and \$950 in 1990) was passed on to the female population in the form of lower wages. He also finds evidence for a small reduction in employment.^{7,8}

These results are both encouraging and discouraging for the proponents of a mandate. They are encouraging because they imply that, for most workers, the probability that any individual will lose his or her job due to health care reform is likely to be small. However, if health care reform is designed to provide an additional benefit of health insurance to the working poor, these results may be discouraging. After all, if employers backward-shift the costs of a mandate onto wages, then the currently uninsured will pay for much of their new health insurance out of their own earnings. Perhaps the working poor would prefer to buy other goods with these wages, such as food or housing.

From the perspective of the working poor, health care reform is regressive not simply because it would require them to buy health insurance in place of other goods they may prefer. Under the current system, if the uninsured get very sick, they will almost always receive some care at minimal cost in a public hospital or as uncompensated care. Health care reform forces them to buy insurance to pay for such care. This economic phenomenon has been called the "Samaritan's dilemma" and has been used as an argument for forcing people to buy income insurance such as Social Security, even though its effects are regressive (Summers, 1989).

Community rating provides further disincentives for the healthy to buy insurance. It requires that all individuals, regardless of age, race, sex, or health status, be charged the same premium. The currently uninsured are disproportionately young⁹. As a result, their health care costs are approximately 33 percent lower than the average, so they will implicitly subsidize the premiums of older workers.¹⁰ Therefore, community rating implies that the young workers subsidize old workers; and since young workers earn less on average than old workers, low-wage earners subsidize high-wage earners.¹¹

To address the regressive burden on low-wage earners and the large increase in employer costs, the Health Security Act includes subsidies to small employers and low-wage earners. These subsidies limit employer contributions for health care as a percentage of payroll. These caps range from 3.5 to 7.9 percent of payroll, depending on the average wage for a full-time equivalent worker. For firms with fewer than fifty employees and average per-full-time equivalent payroll of less than \$12,000, the contribution is capped at the lowest rate. Thus, contributions by small firms hiring predominantly minimum wage employees are limited

to 3.5 percent of payroll. Since our earlier calculations suggested that employer costs could increase by as much as 38 percent, these subsidies significantly alter the burden of the mandate. Clearly, the impact on employment costs is dramatically lower with the subsidies. In addition, the subsidies make the proposed reforms more progressive.

1.3. Employer Responses to Increases in the Minimum Wage

The argument that employees bear the cost of lower wages breaks down for very low-wage workers. The Fair Labor Standards Act, known as the minimum wage law, provides that as of April 1, 1991 most employees may not be paid less than \$4.25 an hour. For employees currently earning less than the sum of the minimum wage (\$4.25) and the hourly cost to the employer of the health benefit (approximately \$1.00 to \$2.00 per hour depending on family composition), employers cannot legally cut wages in the intermediate term. Standard economic theory suggests that firms will cut employment until the remaining workers are each worth \$5.25 to \$6.25 per hour (Stigler, 1946). Some workers earning between \$4.25 an hour and \$5.25 to \$6.25 an hour will lose their jobs.

The crucial question then becomes: How many? For employers of these low-wage workers, health care reform will act like an increase in the minimum wage (in this case minimum total compensation). Thus, we can look at historical experience to determine the job loss associated with a rise in the minimum wage. The magnitude of this employment effect is the subject of a large empirical literature on labor economics. That literature has grown considerably with studies of the increases in the minimum in April 1990 (from \$3.35 to \$3.85) and in April 1991 (from \$3.85 to \$4.25).

Contrary to the expectations of many economists and businessmen, the answer appears to be "not many." Few of the workers earning between a new, higher minimum wage and an old, lower minimum lose their jobs. A series of case studies of the 1990 and 1991 increases in the federal statutory minimum find no employment losses at all.¹²

With sufficiently large samples and lagged effects, a slightly more subtle picture emerges. Many economists have compared changes in aggregate employment of teenagers (16-19) and young adults (20-24) with changes in the statutory minimum, while attempting to control for possible confounding factors such as the number of young people, the overall level of wages, and the size of the military. Those studies report estimates of the elasticity of employment with respect to the minimum wage; i.e., the percentage change in overall employment with respect to a percentage change in the minimum. Thus, if the elasticity is 0.1, then a 10 percent increase in the minimum wage (as we had in 1991) will lower teenage employment by 1 percent. The estimates of this employment elasticity are small and relatively stable. The estimates range from 0.1 to 0.3 for teenagers and from 0.0 to 0.2 for young adults.¹³ Extending the standard time-series analysis through 1986, Wellington (1991) obtains elasticities at the low end of the range; 0.076 for teenagers and 0.012 for young adults.¹⁴

2. The O'Neill and O'Neill Study

In their widely publicized study,¹⁵ O'Neill and O'Neill (1993) make different assumptions in pursuing an alternative approach to estimating the employment effects of health care reform. Their approach yields job loss estimates of 3.1 million. They base their estimates on a series of industry-wide calculations, which we heuristically describe here (the actual computations are more disaggregated). First, they compute the change in payroll costs for each industry, based on the percentage of workers who are uninsured, whether the uninsured are full-time or part-time, whether the uninsured are single or in families, the estimated price of insurance, the degree of backward-shifting onto wages, and the current payroll. On average, they estimate that payroll costs for uninsured employees will rise by 28 percent.

Next, O'Neill and O'Neill translate this increase in labor costs into a percentage reduction in employment using an estimate of the *elasticity of employment with respect to labor costs*.¹⁶ They assume an elasticity of 0.3, which they argue falls in the middle of the range of the relevant empirical estimates. Thus, the 28 percent increase in labor costs for the uninsured translates into an employment loss of approximately 8.4 percent ($0.3 \times 28\%$). Because their data indicate that approximately 32.6 percent of the nation's workforce will be affected by this mandate, they estimate that, overall, approximately 3 percent of all workers will lose their jobs ($= 32.6\% \times 8.4\%$). They disaggregate this figure according to whether the individual is currently covered under another family member's employer-based plan and by industry.¹⁷

Given our analysis of the effects of mandated health benefits, several methodological aspects of their approach appear to upwardly bias their estimates. In addition, their paper

was written before the details of the President's plan were public. Differences between the plan they simulate and the President's proposal suggest several other reasons why their estimates are too high.

- *Choice and application of elasticities.* O'Neill and O'Neill compute the increase in payroll costs for an industry as a whole. Multiplying the percentage increase in labor costs by an employment elasticity, they compute the percentage of workers who will lose their jobs. However, mandated health benefits will not uniformly raise all employment costs as would be required for a strict application of the labor cost elasticities they use. Those who do not have insurance and therefore might lose their jobs are predominantly those individuals in the low-wage industries earning close to the minimum wage. Thus, we prefer a strategy that draws on this analogy by applying the appropriate minimum wage elasticity estimate to the subpopulation of young adults.¹⁸

O'Neill and O'Neill argue that there is a downward bias in the elasticity estimates based on the federal minimum wage analogy. This bias arises because a firm cannot substitute capital for labor in the short-run, and so the long-run response will be more elastic than the short-run elasticity estimates suggested by the empirical literature.¹⁹ Neumark and Wascher's (1992) estimates do allow for these lagged effects. Substituting these estimates to compute an intermediate-run response would cut O'Neill and O'Neill's predicted job loss by almost 50 percent.

- *Assumptions about labor's share of the burden.* O'Neill and O'Neill assume employers shift none of the cost back to employees earning less than \$25,000, and only 50 percent of the cost to employees earning above that level. In their appendix, they do report estimates assuming costs were shifted for employees earning \$15,000 or more, but only at a rate of 50 percent. As we noted in the previous section, the empirical evidence suggests that for workers earning above the minimum wage (plus the cost of the additional mandate), the employee bears nearly all of the increased cost. Assuming an 85-percent shift in costs would reduce their estimates by approximately 30 percent.
- *Plan costs.* Using data from a private benefits consulting firm, O'Neill and O'Neill assume a family plan costs \$5,310 and an individual plan costs \$2,160. These figures are approximately 25 percent higher than the more recent estimates by the Clinton administration of \$1,800 and \$4,200.²⁰
- *No firm subsidies.* O'Neill and O'Neill have assumed no offsetting subsidies to small firms or employers of low-wage workers. The draft proposal calls for limits on employer contributions to between 3.5 and 7.9 percent of payroll. It is the explicit intention of such subsidies to minimize employment effects. For the industries they estimate will lose the most jobs, O'Neill and O'Neill assume payroll costs will increase between 4.0 and 16.4 percent, even after taking into account offsetting reductions in wages. These numbers clearly exceed the caps identified in the Clinton plan.

3. Better Estimates of Employment Effects

In this section, we generate preliminary estimates of the employment effect of the Health Security Act under a set of assumptions that we believe most closely reflects its likely effects. It is undoubtedly possible to generate more disaggregated estimates of the minimum wage elasticity and to apply them to disaggregated population counts. We do not pursue such an approach here. Rather, we provide an aggregate estimate of the jobs lost for the age group considered most at risk due to the imposition of a mandate in both the subsidized and unsubsidized cases.²¹

Table 1 presents estimates of the job loss under the Health Security Act under six scenarios: two sets of minimum wage elasticities (Wellington vs. Neumark and Wascher) and four sets of assumptions about the effect of the employment subsidies. We have already discussed the minimum wage elasticities above. Wellington's (1991) estimates update to the conventional time-series methodology for estimating the minimum wage. Neumark and Wascher (1992) implement an alternative approach yielding much larger minimum wage elasticities and therefore much larger employment effects.²²

Table 1
Job Loss from the Health Security Act

Elasticity	Wellington (1991)		Neumark and Wascher (1992)	
Cap on Employer Contributions	% Reduction in Employment	Jobs Lost (millions)	% Reduction in Employment	Jobs Lost (millions)
None	0.31%	0.347	1.88%	2.109
10.4%	0.13%	0.150	0.82%	0.916
7.9%	0.10%	0.114	0.62%	0.692
3.5%	0.04%	0.050	0.27%	0.307

NOTE: The 10.4% cap corresponds to our estimate of the economy-wide average increase in minimum compensation implied by the Health Security Act's subsidies. It is computed based on the distribution of employees in firms which do not currently provide health insurance classified by firm size and average payroll.

Even given the choice of minimum wage elasticity, there is an issue about how to extrapolate to the population over the age of 25. We define the "vulnerable" population as the set of workers who do not currently have employer provided health insurance and whose hourly wage is less than the sum of the minimum wage and the (unsubsidized) hourly cost of the health benefit (based on the worker's marital status and presence of children). Using Wave 5 of the 1990 Survey of Income and Program Participation (for the Spring of 1991), we compute that the vulnerable population constitutes approximately 24.0 percent of all employees under age 25, but only about 6.3 percent of workers age 25 and over. Thus, it is not surprising that it is difficult to detect an effect of increasing the minimum wage on this group's aggregate employment. Nevertheless, workers aged 25-64 constitute over sixty of all vulnerable workers. The estimates in Table 1 extrapolate from the percentage of vulnerable workers aged 20-24 who lose their jobs to all vulnerable workers over age 25.²³

The rows of the table vary the estimates to reflect different levels of government subsidies. The first row shows the effect of the legislation without the associated subsidies. However, the Health Security Act provides subsidies to firms based on their average per-employee payroll. These subsidies have the effect of capping employer payments for health insurance at between 3.5 and 7.9 percent of payroll. The third and fourth rows of the present the estimated job loss at those subsidies levels. They are computed as if the subsidies were based on individual earnings (as opposed to firm-wide average wages). These caps are too low because some minimum wage workers are in large firms with high average per-employee payrolls and will thus not be eligible for any (or the lower) caps.

The second row reports our preferred estimates of job loss given the subsidies in the Health Security Act. The 10.4 percent figure is our estimate of the economy-wide average increase in minimum compensation implied by the Health Security Act's subsidies. It is computed based on the distribution of employees in firms which do not currently provide health insurance classified by firm size and average payroll.

The job loss implied by this 10.4 percent cap may still be too high. The Health Security Act provides strong incentives to reorganize employment such that low wage workers work for small firms (under 75 employees) with low average per-employee personnel costs. In the extreme case, the magnitude of the subsidy is over \$3,000 per employee. A low-wage worker in a high wage firm is ineligible for any subsidies. The cost to the firm for his health insurance is thus the full 80 percent of the premium (\$2,479 for a couple with children, \$1,546 for a single individual). However, if the firm contracts out the work to a firm eligible for the 3.5 percent cap, then the cost to the firm for his health insurance is capped at \$309 (3.5% of \$8840). Employment costs fall by over \$2,000 for a married person with children, and over \$1,200 for a single individual without children. These subsidies are respectively 25 and 14 percent of payroll. Clearly this large differential in the subsidy creates strong incentives for firms to outsource their relatively unskilled labor-intensive tasks in order to appropriate some of these government subsidies. Thus, the second row (labeled 10.4%) is an upper bound on the final job loss.

Although there are many uncertainties involved in the calculations, our preferred estimates use the 10.4 percent average cap and the Wellington elasticities. Under these assumptions, we estimate that the Health Security Act will result in job loss due to the burden of the required premium of well under one quarter of one percent of total employment (of 18 to 64 year olds). This estimate is less than one-tenth of the estimate of O'Neill and O'Neill using a different methodology which we discussed earlier.

4. Conclusion

In this white paper, we have reviewed the theory behind estimating employment effects of health care reform, critiqued a widely cited set of estimates, and provided alternative estimates of the job loss associated with a mandate. Our best estimate is that job losses will be considerably less than about half of one percent of employment. This estimate is about a sixth of the estimates of O'Neill and O'Neill. Ultimately, the magnitude of these employment effects will depend on the details of the final health care reform legislation.

Our estimates have only considered the direct employment effects due to job losses as employers react to increases in the minimum legal compensation. There are several other possible employment effects which we have not considered here. First, an explicit goal of the Health Security Act is to reorganize the health sector to yield better health care at lower cost to more Americans. In as much as firms see their health insurance bills go down (either due to lower cost of health care itself or due to lower loading factors), firms may increase employment. Similarly, the HSA's guaranteed health coverage should alleviate problems of job-lock and welfare lock. These changes may also increase employment.

On the other side, some of the effects of the plan may yield lower employment. First today some people work in order to gain health insurance. Under the plan, health insurance will be available even to non-workers. This effect is likely to be most important for older workers considering early retirement. Second, in as much as firms pass the cost of health insurance on to workers in the form of lower wages, some people may choose not to work, the cash wage per hour worked has declined. This effect is likely to be most salient among secondary workers.

Finally, it is possible that the shift of expenditures into or out of the health sector (depending on the net effect of the reform on employment in the health sector) may cause a change in total employment. To a first order, however, the dollars spent in the health sector are dollars not spent in some other sector, so net employment effects will be a function of the relative employment in the health sector for a dollar of expenditure. These effects are likely to be small.

Though our employment effect estimates are lower than many other estimates, this does not imply that health care reform will increase health insurance coverage at minimal cost (beyond the explicit on-budget expenditures). Our estimates are low specifically because we expect that firms will successfully pass on the cost of their share of the health insurance premium to their employees in the form of lower wages. Real wages for low skilled workers have fallen considerably over the last two decades, so the assumption of downward flexibility of wages seems plausible. Thus, the currently uninsured will pay much of the cost of the expansion of health insurance. This gives this apparently progressive legislation a significant regressive component.

The obvious way to mitigate the regressive nature of employer-based health insurance finance is to provide government subsidies to low-wage workers. Doing so will mitigate the negative employment effects and the fall in wages. However, doing so is also expensive. The higher the subsidy, the higher the budgetary expense. An alternative is to subsidize only firms that do not offer health insurance (and then possibly only their low-wage workers). However, this creates large incentives for firms to rearrange production to take advantage of the subsidies.

In summary, our best estimates of job loss are much lower than many of those which have been cited in the debate over the Health Security Act. The magnitude of these changes involved in a major reorganization of a major sector of the economy lead us to treat our estimates as informed guesses; with such a major reform unexpected consequences seem possible, if not likely. Nevertheless, our best estimate is that job losses due directly to increased costs to employers will be under one quarter of one percent of total employment. Plausible alternative estimates are much lower. We conclude that direct job loss need not be a major consideration in the evaluation of the President's plan. However, these low estimates of job loss are a direct result of our assumption that most of the cost of the mandated health benefit, including what is nominally the employer's share, will be shifted back to employees in the form of lower wages.

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Endnotes

¹This testimony draws on our ongoing research at RAND. It does not necessarily represent the position of RAND or its sponsors.

²Personal communication with staff at the Council of Economic Advisers indicates that the estimated premiums are \$1,800 for single individuals, \$3,600 for married couples, \$3,700 for single-parent families, and \$4,200 for two-parent families.

³Average earnings come from the Bureau of Labor Statistics, *Employment and Wages Annual Averages*, 1991, Bulletin 2419, United States Department of Labor, January 1993. The computations for employer contributions as a percentage of payroll are as follows: A single individual working at the minimum wage earns \$8,800 annually. Under the mandate, the employer contributes 80% of the cost of insurance (\$1,800). Thus, the employer contributes 16 percent of earnings towards health insurance ($80\% \times \$1,800 / \$8,800$). For a worker in a two-parent family, the contribution is 38 percent of earnings ($80\% \times \$4,200 / \$8,800$).

⁴Subsidies may limit employer contributions to between 3.5 and 7.9 percent of payroll.

⁵The O'Neill and O'Neill report has been cited by the Boston Globe (September 8), Christian Science Monitor (September 24), Newsweek (August 30), New York Times (August 30, September 28, and September 30), San Diego Union-Tribune (September 1 and September 22), Wall Street Journal (August 20), and the Washington Times (August 31).

⁶Over the last decade, the real earnings of low-wage earners have proven to be quite flexible downward. Karoly and Klerman (1993) estimate real earnings for low-wage workers have fallen 15 percent.

⁷Various problems with Gruber (1992) limit its applicability to the more general mandated benefits case. For instance, Gruber (1992) finds that a \$1 rise in the cost of maternity care on average leads to a .22 percent reduction in the probability of employment. Extrapolating to the case of a mandate that increased costs by only \$250, his results imply a 50-percent reduction in the probability of employment. This figure is implausibly high.

⁸Gruber's work revises earlier work on the effects of payroll taxes on wages. Currently, both the employer and the employee nominally contribute 6.2 percent of taxable earnings to Social Security and 1.45 percent to Medicare. However, many economists argue that employees bear all the burden of both the employer and the employee's share in the form of lower wages (Brittain, 1971). Some researchers have tried to exploit slight annual changes in these tax rates, and larger differences across countries, to estimate the extent of backward-shifting of employer contributions. Not surprisingly, the empirical evidence on this question is mixed. Brittain (1971) and Vroman (1974) both use cross-national comparisons to demonstrate that labor bears 100 percent of the burden of the tax. However, Hamermesh (1979) estimates that only 33 percent of the tax is shifted for white males. Because of the disparity in these estimates, we cannot infer much from this literature that is relevant to the debate on mandated benefits. In conjunction with the above analyses of narrower mandates, we tentatively conclude that higher wage employees bear much of the burden of a mandate in the form of lower wages.

⁹For instance, 27.4 percent of individuals 18 to 24 years old are uninsured, whereas only 10.5 percent of individuals 45 to 64 years old are without coverage (Ries, 1991).

¹⁰Using data from the 1987 National Medical Expenditures Survey, Hahn and Lefkowitz (1992) compute mean health care expenditures for the entire United States population, as well as for the subpopulation of 18- to 44-year-olds. For the entire population, the mean annual expense for health care is \$1,521 (computed as the product of two figures in Table 1 of their findings: the percent of persons with expense and the mean annual total expense per person with expense). For 18- to 44-year-olds, the mean expense is \$1,019. For those under 65, the mean expense is \$1,150. Thus, 18- to 44-year-olds have mean expenses that are approximately 33 percent lower than the national average and 11 percent of the average for those under 65.

¹¹The President's plan further subsidizes the rich at the expense of the poor. By financing the benefits expansion through cigarette taxes rather than the taxation of premium contributions, the President implicitly taxes low-wage earners (who may have a greater propensity to smoke) at the expense of high-wage earners (who may have a greater propensity to purchase expensive health care plans).

¹²In a study of fast-food restaurants in Texas, Katz and Krueger (1992) find no employment response to the 1990 and 1991 increases in the minimum wage. Card (1992a) compares the changes in employment in states with high and low wages around the increases in the federal minimum in 1990 and 1991. He also finds no evidence of a regular impact on employment. Card (1992b) analyzes employment responses to changes in California's minimum wage in 1988 for the retail industry, which employs almost 50 percent of the minimum and subminimum workers. By comparing retail trade in California with other states that did not change their minimum, he also finds no employment effects. From these case studies it is clear that firms reactions to the minimum are not simply to fire all (or even a large share of) workers with wages between the old and the new statutory minimum.

...(continued)

¹³Brown, Gilroy and Kohen (1982) and Brown, Gilroy, and Kohen (1983) are the standard references on the effects of the minimum wage. Their two papers survey the previous research, provide updated estimates of employment elasticities with respect to changes in the minimum (as of the early 1980s) and explore the sensitivity of the results to several estimation decisions. Following earlier literature, they estimate the elasticity of teenage employment with respect to the minimum wage, where an elasticity of x implies: if the minimum wage rises by 1 percent, teenage employment falls by x percent. Also following the literature, they estimate this elasticity using time-series regressions on aggregate employment counts since the late 1950s. Thus, the parameter of interest is the percentage change in employment of teenagers or young adults with respect to a percentage change in the minimum wage. Since over most of the post-war period the minimum wage was relatively constant, the estimates are necessarily imprecise. Still, Brown, Gilroy and Kohen (1983) find a small but significant employment elasticity. According to their estimates, a 10-percent increase in the minimum wage lowers teenage employment from 1 to 3 percent (an elasticity in the range of 0.1-0.3).

In the late 1970s and 1980s, the nominal wage remained fixed, but substantial inflation eroded the real minimum's value. This natural experiment provided substantial variation in the real minimum wage, prompting speculation that a larger employment elasticity (more in line with the stark predictions of economic theory) could be found. Brown (1988) provided some back-of-the-envelope calculations suggesting that a large elasticity was unlikely to emerge from extending the time series. Klerman (1992) and Wellington (1989) capitalize on this natural variation in the real minimum over the 1980s to update these estimates. They find even lower elasticities than Brown, Gilroy and Kohen—an elasticity of less than 0.1 for teenagers and approximately zero for young adults. This elasticity implies only a 1-percent decline in teen employment due to a 10-percent increase in the minimum wage.

Neumark and Wascher (1992), exploiting variation in state minimum wages from 1973-1989, also estimate a 1- to 2-percent decline in teenage employment due to a 10-percent increase in the minimum. Thus, it seems safe to conclude, as Brown, Gilroy, and Kohen (1983) do earlier, that there is "...little evidence that the effect of the minimum wage on the employment of white, male, or female, teens differed appreciably from the 1 percent estimate."

¹⁴These elasticities are her base case plus the enrollment to population ratio. Her base case (without the enrollment to population ratio) is not significantly different from zero. Even including the enrollment to population ratio, the estimate for young adults is not significantly different from zero.

¹⁵The study has been cited in the Wall Street Journal (August 20), New York Times (August 30), Newsweek (August 30), Boston Globe (September 8), Washington Times (August 31), San Diego Union-Tribune (September 1), and the results have been entered into the Congressional Record (September 22).

¹⁶O'Neill and O'Neill (1993) base their estimates on the following calculation for those individuals affected by the mandates:

$$\left(\frac{\% \text{ change in}}{\text{employment}} \right) = \left(\frac{\% \text{ change in}}{\text{employment}} \div \frac{\% \text{ change in}}{\text{labor costs}} \right) \times \left(\frac{\% \text{ change in}}{\text{labor costs}} \right)$$

The first quantity on the right-hand side is the elasticity of demand for labor; thus, the relationship may be written as:

$$\left(\frac{\% \text{ change in}}{\text{employment}} \right) = \left(\frac{\text{elasticity of}}{\text{employment}} \right) \times \left(\frac{\% \text{ change in}}{\text{labor costs}} \right)$$

By multiplying this elasticity by the percentage change in labor costs, they compute the relative change in employment.

¹⁷O'Neill and O'Neill identify seven industries characterized by relatively low wages or a large fraction of uninsured that will be extremely adversely affected by the mandates: eating and drinking, private household services, agriculture, repair services, personal services, other retailing, and construction.

¹⁸Ideally, we would like to know how the minimum wage legislation affects all segments of the age distribution, not just teenagers and young adults. However, for most segments of the wage distribution, the mandate will have little effect on employment for those earning greater than the sum of the minimum wage and the hourly cost of the mandate. Thus, older workers will be relatively unaffected by a mandate due to the strong link between age and earnings. For exactly this reason, researchers examining the minimum wage do not estimate elasticities for older segments of the population, since the law is not binding for this group. With regard to a health insurance mandate, older individuals are far more likely to have health care and higher wages. Thus, a health insurance mandate will not significantly affect employment for these individuals. Therefore, the appropriate elasticity for older individuals should be very close to zero, or at the very least bounded by the minimum wage elasticity.

¹⁹O'Neill and O'Neill also dismiss the case-study evidence showing elasticities much closer to zero, because, in their view, it considers only short-run changes, because it uses data from three national chains of restaurants that may be atypical in a number of ways, and because the results do not include ... (continued)

the effect of the minimum on firm entry and exit. This point is made by Neumark and Wascher (1992), whose methodology is designed to accommodate these effects.

²⁰A nationwide survey of employers indicates the average annual premium was \$1,728 for an individual and \$4,260 for family coverage (Sullivan et al., 1992). Assuming an employer mandate did nothing to reduce premiums, O'Neill and O'Neill's figures still exceed the average nationwide cost by approximately 25 percent.

²¹Most investigations of the effect of the minimum wage estimate elasticities for teenagers (16-19) and young adults (20-24) only. These subpopulations constitute the majority of individuals who are most likely to be affected by changes in the minimum wage. If a researcher were to estimate an employment elasticity with respect to the minimum wage for individuals over 25, this elasticity would be very close to zero. Most workers in this age bracket earn more than the minimum, and so the legislation is non-binding for this age group. Analogously, the majority of individuals over the age of 35 already have health insurance or their earnings are sufficiently high that they are at not at risk for losing their jobs. Thus, we look for employment effects only in the subpopulation under the age of 35.

²²These large elasticities have recently been criticized as too large by Card, Katz and Krueger (1993).

²³The estimates are based on employment counts for Calendar Year 1992 from the Current Population Survey (the Household Data) as reported in *Employment and Earnings*, January 1993: 3.3 million workers aged 18-19, 12.1 million workers aged 20-24, and 96.6 million workers aged 25-64. The number of vulnerable workers are 1.5 million aged 18-19, 2.2 million aged 20-24, and 6.0 million aged 25-64. As is noted in the text these numbers are computed based on the percentages of vulnerable workers in the SIPP (0.440, 0.185, and 0.063) multiplied times the 1992 employment counts.

Chairman STARK. Mr. Feldstein, welcome back to the committee. Proceed.

STATEMENT OF MARTIN FELDSTEIN, PROFESSOR OF ECONOMICS, HARVARD UNIVERSITY, CAMBRIDGE, MASS., AND PRESIDENT, NATIONAL BUREAU OF ECONOMIC RESEARCH

Mr. FELDSTEIN. Thank you very much, Mr. Chairman.

I want to talk about three issues. The first is the financing gap and the impact of that gap on the taxes that would have to be raised to finance the Clinton plan as proposed.

Chairman STARK. You mean other than the mandated premiums?

Mr. FELDSTEIN. Exactly. The second point is just what you have mentioned, the taxes that are already in the plan but are not labeled taxes. The hidden taxes, the off-budget taxes, the mandates, and the third is the effect on jobs and layoffs.

I prepared a brief written statement, which I won't read, which I hope that you and the other members of the committee and the staff will read and will read the two short articles that accompany that statement, but let me summarize what I have said in the statement.

First of all, I think that the Clinton health care plan would have a very substantial financing gap. Before the end of the decade, the gap would exceed \$120 billion a year. I think the administration's claim that this can be a self-financing plan, except for the small cigarette tax, is just wildly optimistic.

My estimate of a gap of about \$120 billion a year has through components, which I talk about in the prepared statement, the first are the Medicare and Medicaid savings that are projected. Mrs. Johnson already commented on the difficulty of achieving those just a moment ago. They project cuts of 20 percent in the annual outlays for Medicare and Medicaid. That cannot be achieved by shifting those costs to others as savings have been achieved before because there are no others anymore. The government is on both sides of the ledger and they would, in effect, be shifting it to the alliances.

Second—and that they can't do given their proposed controls on the private insurance.

Chairman STARK. Yes, you can, because the difference is we don't do it exactly the same. We control the premium and the benefit. But quite frankly, the alliance plans—

Mr. FELDSTEIN. Can change.

Chairman STARK. Through risk selection, red lining in effect, and through cutting back benefits by tougher gate keepers. I don't know where—

Mr. FELDSTEIN. I agree they can cut the benefit as a way of achieving this. But that, of course, is not in the plan. And I am talking their plan as it is described.

If they achieved—and it would be quite remarkable to achieve it, even a 10 percent cut in Medicare and Medicaid annual savings, that would leave them with a financing gap from that source alone, relative to what they are projecting, of \$35 billion a year.

The second reason I didn't think they are going to have a big financing gap is that I think their utilization estimates are too low.

This is a major expansion of coverage, not only the numbers of individuals but the scope of services, and I think that for technical reasons that I would be happy to come back to, they have underestimated the cost.

If I am very conservative about the extent of that underestimation, in costs running 5 percent more than they are projecting, then we are talking about another \$35 billion a year that has to be financed over and above what they are describing in their plan.

And finally there is the impact of the plan on the revenue that would be raised by existing income taxes and payroll taxes to the extent that the plan leads to reductions in taxable income from existing employees. And I think that would happen for several reasons. It will shrink revenue under the income tax and the payroll tax.

The higher marginal tax rate, the 7.9 percent payroll premium tax, really a payroll tax for about half of the employees, Chairman Tyson testified, that 7.9 percent increased payroll tax will lead to reduced taxable income as people work less, as they have incentives to convert taxable income into fringe benefits and do all of the other things that we have come to expect from a higher marginal tax rate.

In addition, we have the early retirees that you have discussed extensively that would also shrink the amount of taxable income. And finally there are those dependents, dependent spouses particularly who now work in order to qualify for health benefits or who work for hours that they would like to in order to qualify for health benefits and they too would reduce their working and their taxable income, and therefore their tax revenue collected under the income tax and the payroll tax.

I have made some estimates that suggest on the basis of a detailed reckoning of this that income and payroll tax revenue would fall short of current projections, that is the projections that you would get if you didn't have the Clinton plan, by some \$50 billion a year before the end of the decade, so I add up these three pieces and I find a financing gap of \$120 billion a year once this is fully phased in before the end of decade.

Obviously there are a variety of ways this committee, which would have the responsibility for closing that gap, could do it. If you think about doing it through personal income tax increases and across the board personal income tax increase, you would have to raise everybody's tax bill by more than 20 percent in order to fill that \$120 billion gap. 15 percent marginal tax rate goes to 18 percent, 39 percent marginal tax rates reach nearly 50 percent.

So that is a very big tax increase that would be implied by the administration's plan.

Let me put aside now the issue of the financing gap and the taxes that are associated with it and look at the taxes that are already in the Clinton health plan but are not labeled as such, as you have brought out.

I think there are three things that should be clear. First, I mandate is a tax. Requiring employers to pay more than \$2,000 per employee is like levying a tax on them. And of course, and this is what Mr. Tyson emphasized, some employers are already spending

that much. Therefore, they will not have anything extra to pay and in that sense, for those employers, it is not a tax.

But for those employers that are spending less than the mandated amount, it is a new tax, and it will have effects on employment. There is just no doubt about it. I will come back to that later.

Second, a tax based on the number of employees or the number of dollars in the payroll will eventually be paid by employees. That is what the first witness said. That is what Mr. Tyson said. That is what I believe most economists would agree that taxes, although they are stated as taxes on employers, will eventually be paid, if they are payroll-based taxes, by the employees in the form of lower real wages.

The real wage cuts that that implies for broad classes of employees in the—the real wage cuts implied by the administration's proposal for some classes of employees really is very, very large.

Two working parents would face a combined additional tax on employers—apart from the extra premiums they have to pay out-of-pocket—of \$4,650. To the extent that that exceeds what the employers are now paying, their incomes will fall.

So it is very clearly a tax that is going to fall on ordinary workers, lowering their take home real pay. And that is what the administration, Mr. Tyson, testified to already this morning. Unfortunately, it is a hidden tax. It is an offbudget tax. It is a tax, nevertheless, that reduces real take home pay.

And of course as health care costs rise in the future, that tax will increase, but it will increase outside the normal budgetary process.

The third thing that I think should be clear that the cap, which will affect roughly half we are told of the employees, that 7.9 percent cap is a marginal tax rate. It is not just a tax, but it is a marginal tax rate. If your firm is subject to the cap, any employee who earns another \$100 in that firm will require the firm to send another \$7.90 to the alliance.

That reduces incentives like any marginal tax does. It reduces incentive to work harder, to work longer hours, to take more responsibility. It encourages people to substitute fringe benefits for taxable wages. So it is very important to distinguish that kind of a tax, which has a marginal impact, from the premiums we have today in which, if I earn another \$100, there is no incremental cost to me or the firm.

And the final subject I want to talk about is jobs and layoffs, and I think it is worth setting it in some context. The American labor market really works remarkably well and that is what the previous witness in effect and what Mr. Tyson said.

All we have to do is look back over the last couple of decades as the number of people wanting jobs jumped, thanks to the baby boomers and the married women who wanted to come into the labor force, and basically all of that has been absorbed with no significant increase in the unemployment rate.

We now have an unemployment rate of 6.7 percent, as you know, it is heading down. It will probably get to 6.25 percent. Most people who are unemployed will either be short-term changers of jobs or new entrants to the labor force or reentrants. Essentially true for our economy that anyone who wants to work, can find work somewhere at wages that are commensurate with his or her skills.

So, I think long-term sustained job loss is not the appropriate focus of a concern about the employment facts. Nevertheless, losing a job, being laid off can be a personally very painful and costly experience. Finding new work may involve moving. It may involve taking lower pay. It may involve losing seniority, pension benefits, and other things.

Now, I say all of that because I believe that the Clinton plan, and its very complex financing rules, 7.9 percent cap, a lower cap for small businesses and so on, will have the unintended effect of causing millions of layoffs, and let me be clear, I am not talking about millions of people who are permanently unemployed.

The labor market works well. They will eventually find jobs, but those layoffs will involve unnecessary personal pain, anxiety, moving, accepting lower wages, losing seniority and so on. The written testimony explains some of the reasons for those layoffs.

For example, low-wage workers in firms that are not subject to the payroll cap, relatively high-wage firms, but having some low-wage workers, if the firm—if it is not paying insurance now for those workers, it will find the \$2,000-plus cost for each of those workers, and that will cause firms to lay them off, substituting equipment, sending work overseas, or buying in the same services more cheaply from others.

Now, those low wage workers will in general find other work some place but they will have to take a pay cut in order to do it. Mr. Tyson talks about earlier retirees and making it easier for firms to restructure and become more competitive. That was a nice description for laying people off between 65- and 54-years old.

Some of those people will voluntarily quit, but others will be laid off because the firm will no longer have the obligation of meeting their health benefits during retirement years. Let me give you a more complex example of the unintended way in which I think this legislation would lead to substantial layoffs.

Think about low-wage employees who are now getting insurance. They work in a high-wage firm that will not be affected by the 7.9 percent cap. So those people look like they are not going to be affected by this plan at all. They have got insurance and they are in a plan that is not subject to the cap.

But now a firm—other firms will come along that can provide the same services that those workers are providing to the company at lower cost because those firms are subject to a 7.9 percent cap, or perhaps a lower cap if it is a small firm. So they can offer the first firm, the big firm, they can offer them temporary workers, secretaries, maintenance workers at substantially lower costs, or they can do the work in these other firms which are subject to the cap. Printing jobs, bill paying jobs, computer processing jobs.

They can move those away from the big firm. A cost conscious firm is going to have to respond to that opportunity. Competitive pressures in ordinary industry will force them to do it, to lay off existing workers and to shift to these new suppliers. There are very strong incentives in this system to do that, and I believe that millions of people could find themselves laid off and seeking new jobs because of the Clinton financing plan.

Eventually they would find those new jobs, but the layoff and the job seeking would be a painful and a costly process.

As I said in my prepared statement——

Chairman STARK. I am going to have to interrupt you because we have a vote. So we will have to recess for less than 10 minutes and will be right back.

[Recess.]

Chairman STARK. We can continue. I am sorry for the interruption. Pick up where you were, please. Go ahead.

Mr. FELDSTEIN. Well, while we wait for the other Members to come, let me have another paragraph or two, and then I will stop.

Just to conclude, having talked about the three things that I said I would, I just want to say, as I do in the prepared statement, that I am confident that the goals of this program, expanding insurance coverage, increasing the security of those that are now insured and limiting excess health care spending, can be achieved without these adverse economic effects, without these adverse costs.

I am also concerned, as I think you are, Mr. Chairman, that the Clinton plan, with the kinds of caps that are proposed on future health spending would stifle innovation and would lower the future quality of care. So I hope that this committee will reject the Clinton health plan and will work with others to design a better way to improve the financing and delivery of health care services.

Thank you.

[The prepared statement and attachment follows:]

Economic Effects of the Clinton Health Care Plan

Testimony of

Martin Feldstein

Professor of Economics, Harvard University
President, The National Bureau of Economic Research

before the

Committee on Ways and Means
U. S. Congress
November 4, 1993

I believe that financing the Clinton plan would require an across the board personal tax increase of 20 percent or more. In practice, if the plan were actually enacted, the country would experience larger budget deficits as well as very substantial tax increases. These fiscal effects would slow the long-term growth of real incomes and of our standard of living. In addition, the Clinton plan would cause substantial layoffs and would permanently reduce the level of employment.

Although my testimony this morning focuses on these economic effects of the Clinton plan, I should note that I believe that the Clinton plan would also stifle health care innovation and lower the future quality of care. (See the attached article, "Stifling Health Care's Future", The Boston Globe, September 21, 1993). The goals of expanding insurance coverage, increasing the security of coverage, and limiting excessive health care spending can be achieved through other simpler reforms that would not have the same adverse effects on the economy or on the quality of health care.

1. The Clinton plan has a financing gap of \$120-plus billion a year.

The financing assumptions of the Clinton plan are wildly optimistic. Reasonable assumptions imply that within a few years the financing shortfall would exceed \$120 billion a year. (See "The Health Plan's Financing Gap," Wall Street Journal, September 29, 1993)

- Medicare, Medicaid and other government programs outlays cannot be cut by the 20 percent assumed in the Clinton plan. Even a 10 percent reduction -- quite a remarkable achievement -- would leave a financing shortfall of \$35 billion a year before the end of the decade.

- The uniform national expansion of insurance coverage under the Clinton plan would raise utilization and costs by substantially more than the amounts assumed in the Administration's calculations (which are based on the experience of changing insurance coverage for isolated individuals rather than entire communities). Even a 5 percent extra increase in personal health care spending would add more than \$35 billion a year to be financed.

- Revenue from income and payroll taxes would decline as a result of the reductions in taxable employment income that would be caused by earlier retirements, reduced work by second earners, shorter working hours and conversions of taxable income into untaxed fringe benefits. These reductions in employment income would be caused by the new 7.9 percent payroll tax and by the increased provision of coverage to early retirees and to dependents who now work. Detailed calculations at the National Bureau of Economic Research indicate that this loss of tax revenue would be about \$50 billion a year.

2. Personal tax rates would all have to rise by more than 20 percent to close this financing gap.

All personal tax rates would have to rise by 18 percent to raise \$120 billion in 1998 if those higher tax rates did not reduce taxable income. But such higher taxes would cause individuals to work less and to convert income into untaxed fringe benefits. If that reduced taxable income by just 2 percent, tax rates would have to rise by 24 percent to close the \$120 billion financing gap. Those in the 15 percent bracket would see their tax rate rise to 18.6 percent while the 39.6 percent top rate would increase to 49 percent.

3. Higher employer premiums mean lower money wages.

When two parents both work, their employers would pay a total of \$4650 in mandatory premiums. All economists -- including those of the Clinton administration -- agree that employer payments for fringe benefits are really paid for by employees in the form of lower wages. The Clinton plan would over time cause a substantial cut in real spendable take home pay.

4. The so-called payroll premium is really a payroll tax that would reduce incremental pay and distort behavior.

The total premiums that any firm is required to pay under the Clinton plan cannot exceed 7.9 percent of total company payroll. For any firm that takes advantage of this limit, an extra \$100 of payroll requires sending an extra \$7.90 to the government-mandated health insurance plan. This "payroll premium" is thus a payroll tax on all wages without limit.

Because this tax puts a wedge between what employers pay for extra work and what employees get to take home, it discourages work effort and encourages transforming cash wages into fringe benefits.

5. The increases in utilization over time caused by the expanded insurance coverage would raise employer and employee premiums and reduce take-home pay even more.

The only way to avoid higher premiums would be to deny care through rationing or to cut the range of benefits covered. Although the higher premiums are mandatory payments, the Clinton plan keeps them off budget. Higher and higher taxes (i.e., larger and larger mandatory premiums) would automatically be imposed year after year on employees and employers without Congressional vote.

6. The Clinton financing rules would cause substantial numbers of layoffs of both low and high income employees.

Mandating an employer premium of more than \$2000 per employee would cause many employers to lay off workers with low annual wages. They would reduce the number of part time jobs, would use higher skilled workers or equipment, or would send work overseas. Over time the pretax wages of those who continued to work would fall by more than \$2000, but many workers would lose their current jobs until this wage adjustment occurred.

A firm that pays a 7.9 percent payroll tax (because its average wage is relatively low) would have to pay \$7,900 for a high income employee with a salary of \$100,000. There would be a strong incentive to reorganize, laying off such employees and buying services through independent firms, e.g., fewer company lawyers and accountants and more purchases of legal and accounting services. This would create substantial individual dislocations.

A firm with relatively high wages would pay the schedule of premiums rather than the 7.9 percent payroll tax (since the premiums would total less than 7.9 percent of its payroll). Such a firm would have an incentive to lay off low wage workers and purchase their services through firms that specialize in low wage employees. Again, there would be substantial individual dislocations.

Under the Clinton plan, the government would pay the health premiums of retirees over age 55. This would increase the incentive for firms to lay off older workers since the firms would no longer have to pay post-retirement health benefits.

7. The Clinton plan would have substantial effects on every American family. I urge this key committee to reject this radical proposal and to consider alternative approaches to reforming health care finance.

THE BOSTON GLOBE
Tuesday, September 21, 1993

Stifling health care's future

MARTIN FELDSTEIN
AND KATHLEEN FELDSTEIN

THE CLINTON HEALTH PLAN attempts to respond to the three major concerns about health care that are regularly mentioned in public opinion polls: providing coverage to the currently uninsured, promising that no one can lose insurance because of a change in employment or family circumstances, and halting the rapid inflation in health care costs.

Although we applaud these goals, they could be achieved by a more focused approach that would involve lower costs and less disruption to the good features of the current system.

In the health care reform debate, one very important issue is not getting the attention it deserves: innovation. With the current system of financing health, medical technology has advanced rapidly in recent decades with new pharmaceutical products, electronic diagnostic equipment and surgical procedures. Technological innovation has increased the effectiveness of care, preventing unnecessary deaths and providing more comfortable and useful lives for millions of patients.

The organization of health services has also seen dramatic changes, with the growth of managed care, health maintenance organizations, preferred provider organizations, outpatient surgical centers and coordinated diagnostic services using telecommunication networks. These innovations have permitted very high-quality care at lower costs than otherwise possible.

The 200-page Clinton health plan provides a static blueprint for a national health care system instead of creating a process that will cause health care to evolve in favorable ways. The Clinton approach thus ignores the problem of permitting and fostering innovation in health technology and in the organization of health care.

All of this is particularly worrying because of the administration's emphasis on controlling costs. The danger is that costs will be controlled by refusing to adopt medically valuable technologies that become available in the future. The bureaucrats who would be charged under the Clinton plan with updating the list of eligible services and procedures have no obvious standard for deciding what should or should not be eligible.

If the Clinton plan had been enacted under Lyndon Johnson some 25 years ago, we might today have a health care technology that was frozen back in the 1960s. Would the bureaucrats have approved laser surgery for cataracts? Would CAT scanners and magnetic resonance-imaging equipment that now permit better diagnoses and treatments have been approved, or would they

have been denied as wastefully extravagant technology? We'll never know.

Nor will we know what technology is never developed in the future because the innovators in research labs and hospitals conclude that new treatments aren't worth developing if they are likely to be rejected by the cost-control bureaucrats.

In other countries bureaucrats already control health care services and technologies through national health insurance systems. The tension between controlling costs and providing desirable new technology is often resolved by looking at what is being done in the United States, which sets the standard of medical care for the world. Other nations may decide that certain technologies are too expensive for their government budgets. But they cannot stray too far toward denying useful technology if that technology is being provided here.

If the United States goes down the same road to bureaucratically controlled health care, however, there will be no one to set the standard and define the future of medical science.

The ultimate safety valve for excessive government controls on health care innovation is the right of patients to purchase privately the care not covered by the insurance plan. As of now, the Clinton plan does not explicitly prohibit individuals from buying such additional care with out-of-pocket dollars, or buying insurance that would pay for care not covered by the government plan. But what of the future?

Canadians are not allowed to purchase care from physicians. By law, they can have what the government plan provides, but nothing more. If Canada, not a strange and distant country with a fundamentally different political ideology, adopts such a ban on private care, the United States might do so as well.

The Clinton plan calls for tight "global caps" that limit national health care spending. Such limits on aggregate spending would inevitably mean that the demand for care exceeds the supply of care. With patients and their doctors wanting more care than they are allowed to have, some forms of rationing would be inevitable.

In such an environment of scarcity and rationing, how long would the political process allow some people to buy care over and above the caps? Denying those individuals who want to spend their own money on better health care would stifle the technological advances of modern medicine. Unfortunately, that looks like where we would be heading if the Clinton plan is enacted.

Martin Feldstein, the former chairman of the Council of Economic Advisers, and his wife Kathleen, who is also an economist, write frequently together on economics.

THE WALL STREET JOURNAL Wednesday, September 29, 1993

The Health Plan's Financing Gap

By MARTIN PELLERIN

Financing the Clinton health plan would require substantially more tax revenue than the administration admits. Unless there is rationing and government controls on the use of medical care, the expanded health insurance benefits would cost much more than the plan projects. And the changes in the behavior of firms and individual taxpayers caused by the plan would reduce total government revenue by at least \$50 billion a year (at 1997 levels).

There are two primary reasons that the actual insurance costs would exceed administration projections: Medicare and Medicaid savings would be smaller than projected and the public's utilization of medical services would be greater.

The Clinton plan claims that caps on Medicare and Medicaid spending would cut the recent double-digit rates of spending growth to only 4% a year within five years. As a result, Medicare and Medicaid spending would then be 20% below the amount that is now projected without the Clinton plan.

No Cost Shifting

No details are given about the reductions in care that would be needed to achieve these massive spending cuts. They cannot be achieved (as Medicare savings have in the past) by shifting costs to other patients, since the Clinton health plan would be paying the bills for those other patients as well. Nor can a 20% cut in outlays be achieved by reducing waste, fraud and abuse. It would require substantial reductions in the actual volume of services given to the aged and the poor. It's not surprising that members of the Democratic leadership in Congress have already made it clear that they will oppose such cuts in health care spending.

Even a 10% reduction in Medicare and Medicaid outlays would be a remarkable and unprecedented achievement. It is as large a cut in these politically sensitive programs as can credibly be imagined. It would nevertheless leave a financing gap equal to half of the plan's projected 20% decline in Medicare-Medicaid outlays. At 1997 levels of Medicare and Medicaid spending, that's equal to \$35 billion a year.

The actual costs of the Clinton plan would also exceed the administration's projections because utilization would increase by more than the administration assumes. The plan increases insurance coverage substantially: covering the 37 million who now lack formal insurance, raising everyone's insurance to the standard of the Fortune 500 companies, covering all pre-existing conditions, and including some care for mental health and substance abuse.

An increase in insurance coverage inevitably increases the utilization and pro-

vision of medical services. The government actuaries recognize that but substantially underestimate the likely magnitude of the increase. This underestimation occurs because the actuaries base their estimates of utilization under the Clinton plan on experiments at the RAND Corp. in the 1970s in which samples of individuals were induced to swap their regular health insurance policies for new RAND policies that had different deductibles and co-insurance rates.

The RAND analysts found that individuals with more comprehensive insurance used more health services. But changing the insurance policies for a sample of isolated individuals in this way does not alter the prevailing standard of care in a com-

existing government revenue. Consider first how the "payroll premium" tax would shrink taxable wages and salaries and thereby reduce all forms of income and payroll tax revenue.

Under the Clinton plan, employers would pay premiums of \$2,240 a year for employees in two-parent families (and corresponding amounts for other types of employees), subject to a maximum payment of 7.9% of the firm's total payroll.

It is this limit of 7.9% of payroll that converts the "payroll premiums" from a mandatory insurance premium into a 7.9% payroll tax that generally discourages work and encourages individuals to take compensation in nonpayroll form. If a firm that is subject to the 7.9% cap adds a new

The Clinton health plan would reduce government revenue in other ways as well. Providing health insurance to everyone would encourage more early retirement, less employment among second earners who now work to obtain insurance, and more shifts to the underground economy. All of these changes would reduce income and payroll tax revenue. The plan's complex system of subsidies and premium caps for small firms and for firms with low average wages would also encourage the outsourcing of jobs in ways that reduce payroll premium revenue.

The combination of all these changes would probably reduce tax revenues by at least \$50 billion a year. Adding to that the \$70 billion of extra costs implied by excess Medicare-Medicaid spending and by increased utilization implies a total annual financing shortfall at 1997 levels of over \$120 billion.

Closing a \$120 billion annual financing gap would require a massive increase in tax rates. In 1997, \$120 billion would be 18% of currently projected personal income tax revenue. But an across-the-board 18% increase in all personal income tax rates wouldn't raise an extra \$120 billion because higher marginal rates cause reductions in working hours, changes in the form of compensation to nontaxable fringe benefits, and shifts to less onerous but lower paid work.

Tax Boost

Calculations using the TAXSIM Model imply that raising an extra \$120 billion in 1997 would require increasing marginal tax rates by at least 24% even if those higher tax rates only reduced taxable income and wages by as little as 2%. A taxpayer who is now paying a 15% marginal tax rate would face a rate of 18.6%. A taxpayer at the current top 39.6% personal rate would see that rate rise to 49% or higher.

The Clinton plan promises attractive features to a wide range of interest groups to get their support. Senior citizens would get free prescriptions. Big business would be able to shed responsibility for the health costs of early retirees and would have health costs limited to 15% of payroll. Small business would get subsidized insurance. Most employees, and especially lower wage workers, would get substantial improvements in their insurance coverage. All of this financed by increasing an annual per-capita cigarette taxes by \$6.

The American public needs to know the true total cost of the plan. Unless voters want to pay increased taxes of at least \$120 billion a year, Congress should be working on alternative lower-cost ways of dealing with our health care problems.

Mr. Feldstein, former chairman of the president's Council of Economic Advisors, is a professor of economics at Harvard.

Board of Contributors

The only way to avoid these increased costs would be to impose a system of controls and rationing that denies patients the care that they and their doctors want.

munity. The RAND study thus measures the extent to which individuals with more insurance increase their demand for care but it tells us nothing about how the prevailing standard of care would change if everyone had the comprehensive insurance proposed in the Clinton plan.

It is of course difficult to judge how much more it would raise the volume and intensity of medical care than the reactions predicted by the RAND experience. But the effect of providing universal comprehensive insurance is likely to be very substantial. A very conservative estimate would be that total personal health spending would be increased by at least 5%, a 1997 increase of \$35 billion.

Combining the administration's overoptimism about Medicare-Medicaid savings and its understatement of increased utilization implies at least \$70 billion a year of extra program costs. This is not intended as a precise estimate, but as an indication of the minimum amount by which the administration's current estimates understate the true financing costs.

The only way to avoid these increased costs would be to impose a system of controls and rationing that denies patients the care that they and their doctors want. Perhaps that is what is meant by "global budgets" for private care. If that is the essence of the Clinton plan, it deserves to be the focus of our national debate.

The administration's estimates also essentially ignore the impact of the plan on

employee who is paid \$20,000, the employer must pay an additional "payroll premium" tax of 7.9%, or \$1,580. If the firm increases the pay of any employee by \$1,000, it must pay an additional "payroll premium" tax of \$79. In other words, the payroll premium is a 7.9% additional tax on incremental wages (except for those firms at which 7.9% of total payroll exceeds the total mandated premiums).

The immediate effect of imposing the payroll premium tax would be to discourage hiring, to increase layoffs and to reduce profits in firms that now pay less than 7.9% of payroll for health insurance. The reduction in profits would not be permanent because capital would move to other uses where it can earn a higher return. After a few years, the reduced demand for labor would cause wage rates to decline by the 7.9%.

Experience shows that a tax on marginal wage and salary income reduces working hours, encourages the substitution of fringe benefits for wages, and shrinks taxable compensation in other ways. Calculations with the National Bureau of Economic Research TAXSIM Model imply that a new universal 7.9% payroll tax would cause changes in behavior that reduce total 1997 wages by about \$115 billion and cut the federal government's tax revenue by \$49 billion—\$24 billion less in personal income tax payments, \$16 billion less in employer-employee Social Security tax payments and \$9 billion less in payroll premium payments. If only two-thirds of employees were in firms subject to the 7.9% cap, these amounts would be reduced by one-third.

Chairman STARK. Well, I probably would be more draconian than the President. I know of no other way. There is no other country, no other system, where an attempt is not made to set some limits or caps, be it price controls or actual budgets, on health spending. And for better or for worse, we do it in defense, and God knows, if Star Wars isn't creative enough for you on some kind of a budget I don't know what is. I don't think that it follows necessarily that unfettered spending or undisciplined spending necessarily creates any more creativity.

I am inclined to agree with Mr. Klerman in that I look at this on the smaller companies more in the nature of an increase in the minimum wage. If we just said there will be a 50 cent an hour increase in the minimum wage but it will be in the nature of benefits, and therefore if you have insurance or provide insurance at some minimum level, it would be a subminimum wage for those companies who already provide benefits.

I think then the economic data show that we wouldn't have a whole hell of a lot of job loss. At least that hasn't been the case. Do you buy that?

Mr. FELDSTEIN. Again, I would distinguish permanent net job loss from the flow of layoffs as firms reorganize in response to this.

And I think—and I testified that the permanent net job loss would be relatively small. It would be this minimum wage effect.

Chairman STARK. All right.

Mr. FELDSTEIN. But net is the key word there. There are going to be a lot of people who lose jobs and then go out and find other jobs, prospect at lower wages, perhaps some place else, perhaps—

Chairman STARK. What is McDonald's going to do?

Mr. FELDSTEIN. It is not McDonald's—McDonald's is your minimum wage case. Think about a firm that has some general high-wage employees, but also has a large number of low-paid operatives.

Chairman STARK. They already have insurance. They really do.

Mr. FELDSTEIN. That is right. They have insurance, and now along comes another firm and says you are paying for these workers and I can get you the same workers, the same quality workers cheaper.

Chairman STARK. We have that. We have what these guys call lease—

Mr. FELDSTEIN. That's right, but now you have a much bigger incentive to do it. What is the firm going to do? The first firm is going to say, I will lay them off. I will buy—

Chairman STARK. But you can lease them back.

Mr. FELDSTEIN. But it is not going to be the same guy that walks out the door and gets the job.

Chairman STARK. But they do. In California that has become a cottage industry. You take all the employees, mostly firms with under 200. And I don't know—let me try this just as an alternative and because Mr. Klerman suggested that the subsidy if we gave it only to the low wage, uninsured, would perhaps—would lead to some restructuring. I believe you said that in your testimony.

Didn't you say in your testimony that if we only directed the subsidy to those low-wage uninsured firms, that there would be some restructuring going on and I think you both agree on that.

Mr. KLERMAN. Right.

Chairman STARK. OK. Try this. Neither of these are original. Marty you will recognize the first one. I don't really care whether we run this on budget or off, between you and me. There are some political implications there, but we are dealing with the same dollars and the same people are paying it and getting the same benefits. Whether we run it through the budget or outside the budget to me is a matter of indifference.

And I don't suppose that anybody has suggested anything, other than this psychological or political question. Would I get beat up more by my opponent for being a big tax or big spender? Yes, but I have had 20 years of that. That isn't the concern.

But I have approached it two ways. One, if the benefits were not as generous, and that is my reaction to costs, except for the poor, so basically you can combine Medicaid into Medicare, and if you are poor, we pay the copays. All benefits the same, save the copays and the deductibles. The things we do to you are the same in everybody's plan, it is just what you get in 1 year and what you pay as a down payment or a copay.

And that is a fairly linear relationship. So if you get the costs down to say where Medicare is, the rest of the benefits then become the subject of union negotiation or the generosity of employers or the responsibility of the individuals. But you put in place with a \$2,500 out-of-pocket cap, approximately a Medicare benefit at Medicare rates. In 1991 figures—that was 50 cents a hour, a \$1,000 a year.

Mr. FELDSTEIN. The cost of such \$1,000?

Chairman STARK. For an under-65 single employee, maybe 60 cents is the correct figure. Those figures would be higher now. And you say, all right, let's call it \$1,200, it is easier for me to do the monthlies. You want an individual mandate, that is a mandate. From the day you are born you are in the plan.

However, if you choose to buy one elsewhere, join Kaiser, buy Blue Cross, and it is on your tax return and your parents, if they take you as a deduction and if you get it at work, you clip another form on your tax return and you don't pay the \$100 a month, you get a credit for it. That seems so much simpler, and if you don't file a tax return, you are presumed to be in the Federal penitentiary or you are so poor that you don't file a tax return and therefore we pay it for you anyway, and it is a seamless way of getting around from reapplying and all the rest.

Does that soften the impact? I don't think it changes Mr. Klerman's approach. Does it soften the impact as you see it if we did something as to its effect on the economy?

Mr. FELDSTEIN. If I understand it correctly, you don't have any of this employer-based requirement; there is no 7.9 percent?

Chairman STARK. Actually, yes, there is. The employers are on the hook for 80 percent of that \$1,000 and the employee is, if they are above 1½ times poverty, for their share. And on the other hand, if the employer already has a plan—

Mr. FELDSTEIN. Do you have caps on the amount that employers will pay or it is a fixed flat percent?

Chairman STARK. In other words, if I presume the Medicare rate, I also presume it will go up. But—

Mr. FELDSTEIN. But it is \$80 a month—

Chairman STARK. For the employer and \$20 a month for the employee.

Mr. FELDSTEIN. That eliminates a lot of adverse effects in the administration's plan that I talked about. You don't create incentives, as least as I understand what you are saying, you don't create incentives for new firms to come in and bid away jobs and cause firms to lay someone off. You don't have any of the early retiree incentive for firms to lay off retirees. I don't know what you do about those.

Chairman STARK. The early retirees in my book were giving away too much too early in the bargaining. There is a strong case to be made for the General Electrics and the General Motors and the Fords that they have been ponying up, but nonetheless for the last how many years they have been paying a big bill.

They have not been reserving enough as the accountancy board pointed out, but they could buy the argument that because they have done the right thing at great cost, they are perhaps entitled to some relief. I happen to think it is enough relief if you guarantee them that you cap the rate of increase. What they have now is a bottomless pit of increasing costs, and they didn't see the catastrophic.

The one thing we gave them in catastrophic when we put the cap on, for those firms that have a contractual obligation for the supplemental part of Medicare, we saved them a lot of money right then because we capped it out.

And what I am saying is if we cap off these unfunded liabilities, that is a hell of a benefit to these big corporations. But we offered a little more at the beginning and so, you know, I am like the sales manager, I can't go up again. And I have already offered you too much for your trade-in, and so I think we are hooked with that.

But I think there are savings in limiting the rate of increase on those unfunded liabilities, most of which have been swallowed. So the—

Mr. FELDSTEIN. I think what one would bear in mind apart that this transfers some money from the taxpayers to these firms is that it is going to provide a stronger incentive for those firms to lay off people between 55 and 64 who don't want to be laid off.

Chairman STARK. Yes, they do.

Mr. FELDSTEIN. It is not clear why as a matter of public policy we want to encourage firms to do that.

Chairman STARK. The only reason I can see to stay on the assembly line for 30 years, is that, if I get 30, I get to go fishing.

Mr. FELDSTEIN. It is not everybody who is 55-years-old who will be laid off in this who is an operative, a manufacturing operative in one of those half dozen firms. There will be a lot of other people whose firms are going to say here is somebody who it is now cheaper for us to lay off.

And I don't see why we want as a matter of public policy to induce those additional layoffs. I think the other point is that the argument that the administration was making that this somehow will make with competitiveness is inconsistent with the argument with—

Chairman STARK. With NAFTA.

Mr. FELDSTEIN. Was inconsistent with the argument that these fringe benefits are really paid for by the workers in the form of lower wages than they could otherwise get. They can't have both of those. They have to think that this a burden being borne by the firm that shows up in prices which hurts competition abroad, which I don't believe, or what I do believe is that their other statement that this is money that otherwise would show up in cash wages and, if so, has nothing to do with competition, it has to do with buying political support from certain groups.

Mr. KLERMAN. I have two comments which are supportive of the scheme that you outlined. The Clinton plan as proposed is relatively generous from two dimensions. The first dimension is that there are a lot of different services that are covered and inasmuch as you cover less services, you lower the cost of the plan. And that obviously lowers the employment effects because there will be less money that you have to find somewhere.

The second dimension is that the Clinton plan is relatively generous in the terms of insurance themselves. Many of us who have insurance pay some form of copayments and deductibles and work that had been done at RAND in the last 20 years has shown that copayments and deductibles have large effects on the total cost of health insurance, how much health care the people consume, and they have, except in rare instances, minimal effects on health outcomes.

And so the more generous we make the plans by having lower copayments and lower deductibles, the higher will be the cost of the plan and at least the evidence in the RAND Health Insurance Experiment was that there would be no effect on health benefits.

Chairman STARK. Let's me see if I have this about right. RAND initially did a study that indicated that oftentimes a copayment deferred or eliminated necessary medical care, but a subsequent study found that that was not the case. Am I—

Mr. KLERMAN. The conclusion from the Health Insurance Experiment, is as you said at the end. With two exceptions, I think, eye glasses and I don't remember what the second exception was, that you don't find large health effects from the deductibles.

So the basic analogy is that if you get really sick, you are going to go way over the deductible and the copayment anyway and if you don't get really sick, then there is little evidence that those health services make big differences in health status. And so that implies that a plan with higher copayments and higher deductibles would be cheaper and therefore—

Chairman STARK. And not affect the quality all that much.

Mr. KLERMAN. Not affect quality where quality is measured by the health status of the work force or the population as a whole. That may not be true if you think about the population as a whole that doesn't have health insurance at all where they are getting no care or care in the emergency rooms, but in the range of guaranteed coverage to everyone there is not strong evidence that it really matters how big the deductibles are, but the price effects are large, they are like 20 or 30 percent of total costs of health care.

Chairman STARK. Thank you. Mr. Grandy.

Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Following up on your last comments, Mr. Klerman, you and I had an opportunity to talk a few minutes before we resumed. You mentioned that there were no studies that you were aware of that indicated that preventive care would extract huge savings from the system. That relates to what you were just talking about.

We have heard a lot about preventive care and Mr. Tyson this morning mentioned that when I asked her to list off some of the inefficiencies of the system and where she was going to get those huge savings. That was one of the things she mentioned.

Would you and Mr. Feldstein, if you choose, elaborate on that? Is preventive care something that we are going to put in the system and achieve great savings?

Mr. KLERMAN. This is not my field of expertise. I have read some of the literature and my impression is that the evidence that preventive care saves money or that it improves health status is relatively weak. There is some evidence on that that came from looking at some of the Medicare expansions that were passed in the last couple of years, and asking whether or not there were improvements for new mothers and young children, for example.

And my impression is that the evidence has not supported that. I sat on a panel that discussed that a year or two ago. And there was no evidence for that at that point.

Mr. MCCRERY. OK. That is fine.

Mr. KLERMAN. The reason is that preventive care we give to everyone and only some people get sick, and unless the illness that you are searching for is very common, you are going to search through a lot of people, a big hay stack looking for needles, and unless there are a lot of needles out there, you do not save a lot of money when you find the needles. It is not cost-effective.

Sometimes you actually provide some small health benefits, but then you have to weigh the health benefits of finding the needle in the hay stack and whether or not those moneys could have been spent somewhere else better.

Mr. MCCRERY. Mr. Feldstein, did you have a comment on that?

Mr. FELDSTEIN. I would generally support what we just heard.

Mr. MCCRERY. I am no expert on this area of health care, either, but my investigation, brief as it has been, into the matter is the same. There is no evidence that preventive care is going to exact great savings to the system, so if we want to include preventive care, I think we should do it for other reasons than the great savings.

Mr. Feldstein, in your testimony the last thing you said was that in order to change the financing of the system and solve some of the problems in the system, there are better ways to do it, basically, than the Clinton approach.

Would you elaborate and give us some examples of some things that you think could be done?

Mr. FELDSTEIN. That was probably something I should not have said. I really wanted to focus my testimony on the question that the committee put about the economic effects on financing and on employment of the Clinton plan rather than to drift off into a variety of alternatives, and so I would rather not talk about either my own thoughts or some of the other plans, interesting though they

are, that are on the table, and stick, if we can, in the limited time to these economic effects.

Mr. McCRERY. Well, you are right. You shouldn't have included that in your statement. Let me see if I can pin you down, then, on a specific related to what Mr. Klerman was talking about. This is the evidence that RAND Corporation has certainly provided us showing higher copays, coinsurance, and cost sharing has an effect on utilization by the consumer of health services. There are some proposals out drifting around on medical savings accounts, on large deductible insurance policies.

Would you say that is a way to get at overutilization of the system?

Mr. FELDSTEIN. I think it is. I think that we have an insurance system now that has very small copayments, very small deductibles, in part because of the handiwork of this committee through the tax law making it cheaper for people to buy health insurance, lowering the cost of health insurance so that it is being bought with somewhere between 50 and 65 cent dollars, depending on your marginal tax rate, so, of course, people overinsure, and some of the proposals have included this.

If we limit the tax subsidies for insurance, then I think individuals would have less of an incentive to buy—overinsure in that way and the larger copayments and deductibles will rein in some of the spending.

Mr. McCRERY. Let me just interject, Mr. Klerman, I would like to have your comments as well, but I would like for both of you to finish. In the Clinton plan, we hear administration witnesses all say, oh, well we have deductibles and we have copays.

For that very reason, Mr. McCrery, we want consumers to be responsible. My question is, are the deductibles and copays in the Clinton plan sufficient enough to effect that behavior in a meaningful way?

Mr. FELDSTEIN. When I looked at those my impression was that they were very small and that really wouldn't have much bite, and that while for low income individuals that may be the appropriate level, that you want to limit the maximum amount of pocket relative to their income to a small amount, even though that leads to more utilization of care.

For higher income people you would like to have larger deductibles and copayments. I think people wouldn't have chosen them if we didn't give them a tax incentive.

Chairman STARK. If the gentleman from Louisiana would yield? There is a concern that these copays, are around \$10, and when you are talking about people, with \$10,000 and \$12,000 of income, those become relatively substantial at that income level. They are a matter of indifference to Members of Congress, but I think that is what you were saying, that these are pretty hefty copays for very poor people, but not for the average working.

Mr. FELDSTEIN. Again, the way to think about, and the way you described your own plan in terms of the maximum amount over a period like a year, not the amount that you pay on any given occasion, so—

Chairman STARK. Well, there is a premium of a couple hundred dollars as well, so it is not—

Mr. FELDSTEIN. I think that is what you want to look at. You want to look at the overall.

Chairman STARK. Thank you for yielding.

Mr. MCCRERY. Yes, sir, Mr. Chairman, but the premium is different from the copays or coinsurance. In fact, the premium, I would submit, has the perverse effect. Once you pay that premium you feel like you are entitled to everything under the plan so you are going to go get it. If you require coinsurance, though, or a large deductible and out-of-pocket expenditures, it is quite a different effect.

Mr. Klerman.

Mr. KLERMAN. I want to make one comment, one narrow comment about financing. Many of the effects, the secondary effects that Mr. Feldstein talked about are due to the fact that the plan, the Clinton plan as currently envisioned has subsidies which go to firms for the 80 percent part which are a function of the size of the firm and its average wages. That causes, as I say also in our testimony, large incentives for firms to reorganize.

It also means that we are not providing the subsidies to the people who need it according to the rules we just said, that they be relatively low wage workers. The example we usually give is the mail clerk in a law firm who because of the way the Clinton plan is specified will not be eligible for subsidies and the firm will end up paying the full amount, the full 80 percent.

There may be some subsidy under the plan, but if our assumptions are right, both Mr. Feldstein and myself, then they will also end up seeing their wages fall, and so that if we go to a different plan, for example, the one that Chairman Stark proposed or some other scheme, then one thing to do is to make those subsidies go to individuals with families who have low wages, low earnings as opposed to going to firms which are categorized in a certain way or to individuals with firms.

One alternative you can consider is the possibility where you have a husband who makes a lot of money and a wife who makes a small amount of money, or vice versa, then even an individual plan may give subsidies to a family that doesn't really need it, whereas if we go to a plan that looks at family income like the tax system does, then we can focus the subsidies on low income families which might need the money, so there are both equity and efficiency arguments from the fact that we are targeting the subsidies at small firms and firms with low payrolls.

I think that both arguments apply, that we need to think about that carefully. There are obviously political arguments that run in the other direction, and those aren't my field.

Mr. MCCRERY. Thank you.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I apologize for not being here at the beginning of the questioning. Mr. Klerman, on page 4 in your testimony you were talking about community rating; basically young workers subsidizing old; low wage subsidizing high earners.

What Mr. Tyson is talking about, this cross-subsidization which is built into the Clinton plan, is that not only with the community rating which occurs under any plan shifting from our current struc-

ture, but the way in which the government subsidies are built into the alliance structure. The way in which the alliances will be drawn not only creates, in my opinion, cross-subsidization within an alliance, but based upon the makeup of an alliance, a consolidated metropolitan statistical area versus one that is not, there is going to be a significant difference between alliances.

First of all, do you agree with me there is going to be cross-subsidization in the alliances?

Mr. KLERMAN. Yes.

Mr. THOMAS. I don't know of a mechanism within the current plan that will assist in the differential of cross-subsidization between alliances. There is a structure for the National Health Board to assess the costs and redistribute it, but all that does is bring the hidden cross subsidizations to the surface. The next round that is hidden drives them in another direction. That just exacerbates the difference by elevating the cost to the upper level. I am trying to figure out how they are going to deal with this in the real world if they ever impose it. Do you have any comment on that?

Mr. KLERMAN. There are going to be problems of cross-subsidization. It is going to be true that there is cross-subsidization between people within alliances and also across alliances.

Governor Wilson in California has commented that we in California have a serious problem with immigrants, many of them illegal, and those costs will obviously—

Mr. THOMAS. We have agreed to not have them in the plan. The Clinton plan says illegals don't exist as far as the Clinton health plan was concerned except for a special fund that is going to deal with illegals, AIDS, tuberculosis and a number of other problems, so I think we set them aside in terms of cross-subsidization.

Mr. KLERMAN. We will still have the cost shifting.

Mr. FELDSTEIN. It is a mind-boggling complexity and one wonders why, I mean, why in the world do it through this mechanism when it is really unnecessary.

Mr. THOMAS. That is the ultimate irony of this, because we both think we can come up on both sides of the political spectrum with solutions to the problems, as everyone defines the problems, and it doesn't get this complicated.

Mr. Klerman, on page 5 in your document you are talking about the cost shifting. It is true, that you only have certain sources, that is, profits, higher costs of the product or lower wages. I agree with you or with the other studies that have shown about 85 percent, are borne by lower wage earners.

Don't you run into a problem at minimum wage level in which you can't go below the minimum wage? Do you face a real decision about continued employment more so than any other structure? Do you agree with that?

Mr. KLERMAN. I agree with that. I think it is true that for workers that currently have wages that are low so that their wages cannot be shifted that there will be some loss of employment.

Mr. THOMAS. So we have cost shifting in terms of low wage earners subsidizing high wage earners and we have necessities of economics putting greater job pressure on the low wage folk at minimum wage than the higher wage. If you work this dynamic out in

every alliance across the country, how do you come up with less than one-half of 1 percent impact on employment?

Mr. KLERMAN. The argument you made about low wage workers implies that the Health Security Act raises the minimum wage, really minimum compensation because firms now have to pay both the minimum wage and this benefit less some set of subsidies, but we have just had two major increases in the minimum wage in 1990 and 1991, and the evidence there is that job losses due to those increases have been relatively small.

Some studies have actually found no effect at all. More careful studies using more sensitive methods find small effects, but they imply that the layoffs even in the minimum wage of 10 or 20 percent is likely only a couple percent.

Mr. THOMAS. That is the old world. You have a whole new operation where you are really paying for the decisions you make instead of the government holding the bag on the fringe benefits and all the rest.

Mr. Feldstein, jump in because—

Mr. FELDSTEIN. As I said in my remarks, sustained job loss, sustained unemployment in this economy is a rare event. The system has ways of finding ways for people to come in.

Now, when you get down near the minimum wage you do come to the one sensitive piece, but what would actually happen, I think, is that the people who got laid off because of this would go to work for firms, small firms which would qualify for the 3.5 percent or 4.5 percent cap, so that if they are making \$15,000, you are talking about \$500 or \$600 of extra costs or on the order of whatever that would be, 30 cents an hour, so there will be that strange safety valve for them in the system, so I don't think of permanent job loss as a significant focus here.

Mr. THOMAS. But we certainly see churning.

Mr. FELDSTEIN. A lot of churning, and churning, that is why I emphasized how painful.

Mr. THOMAS. That is psychologically damaging.

Mr. FELDSTEIN. It is a lot more than that. A lot of them are going to churn themselves out of a good job and into a not so good job. The administration has testified that the real costs of this are going to be borne by the workers; their wages will fall. If you take two workers who are currently getting insurance and the plan is costing \$2,000, \$2,500, a good plan, they are nevertheless going to have a combined employer payment of twice that, about \$4,600. That is going to come out of their wage collectively, husband and wife's wage, so we are really talking about a lot of churning and a lot of reduction in real wages.

Mr. THOMAS. Your emphasis on firms supplying workers at lower costs can be compounded by the fact that, given the temporary movement that we have, you have got the 30-hour minimum for paying all of the health care costs as well. I just think there is going to be an enormous boost in temporary workers under 30 hours with an enormous advantage of not carrying these costs. These people are going to be supported in the system by all the others. That is another example of cost shifting.

Mr. FELDSTEIN. It is prorated, though, isn't it, under 30 hours? It is prorated.

Mr. THOMAS. That just gives you the percentage reduction in terms of the marketplace, but Mr. Tyson, stated that this is going to solve the health care needs. It is going to lower the costs. It is going to provide universal coverage. It is not only going to reduce the deficit, but it is going to create, in a relatively short period, a windfall for employers who are either going to raise the wages, hire more workers or invest in more resources. This is another sweetener to the pot which I already thought was too sweet to begin with.

Now, how in the world do two economists looking at the same structure arrive at her viewpoint in which there are no taxes involved with this scenario of the world, while you are looking at it seeing taxes? I assume we are not even appreciating all of the spin-offs on the deficit reduction and the rest.

For folks watching, at some point we have got to get into basic assumptions and calling a spade a spade, as the chairman said. I don't care what you call it. It is a cost that is assessed and it is going to have to be dealt with. At what point do you think this debate is going to firm up a little bit, and we are going to be dealing with a realistic view of the world?

Mr. FELDSTEIN. Well, at some point you are going to ask the administration or you are going to consider point by point the specific changes in Medicare and Medicaid rules that they think will cut Medicare and Medicaid spending by 20 percent. At some point you will call in witnesses who are hospital administrators, chief physicians and others and say, think, doctor, what would happen if this plan had been in effect for 15 years so that your average cost per patient today would be 20 percent, 25 percent lower than you are allowed now.

The insurance companies through the alliance would have told you year by year you couldn't have had it. How much would you have cut nurses' salaries? How much would you have cut the salaries of other staff? Which things would you eliminate from your hospital? Then you will learn what really is the reality behind what they are assuming will happen.

If you say, you know, that isn't going to happen, we are not going to vote those changes and the public isn't going to sit still for those reductions, then I think you will realize why, and maybe the administration will realize why their plan is not feasible.

Mr. THOMAS. The reduction over 5 years is just \$6 billion short of the entire budget for Medicare in fiscal year 1993. That is \$130 billion and they are going to cut \$124 billion over 5 years. Thank you very much.

Chairman STARK. I just wanted to finish up. We talked about the tax and premium. From an economist's standpoint, with the exception of the emotional issue which I will just stipulate that the three of us are not trained to ascertain, does it make any difference, let's just say in the President's plan, whether we call the mandated premium a tax or premium?

One would put it on budget, one arguably would run it through the aggregate accounts, but does it make any difference?

Mr. FELDSTEIN. There are three issues. One is just a pure labeling. Labeling itself can't do anything. On the other hand, running it through the accounts means that when you want to raise it, you

have to think about it in the future. You have to vote it. It is subject to the balancing of taxes and so on, so I think that would be a discipline, a rationalizing thing which is not there now.

Second, there is the 7.9 percent cap. That converts a fixed tax, the \$2,200 for a married employee, converts it into a marginal tax rate. That is really very important, and the administration keeps shuffling that under the rug, but that is very, very important because what it does is change incentives about how many hours I work, whether I want to be compensated in cash or in fringe benefits, whether I want to retire or not, so it is going to have a big impact on total taxable income.

Chairman STARK. Well, where a person is earning enough for that to be a factor, the plans cost mostly more than 80 percent anyway.

Mr. FELDSTEIN. But let's say a plan currently costs \$3,000, it is a very generous plan. The point is the number isn't really relevant. What is relevant is whether the firm is subject to the cap or not.

Chairman STARK. Rather than the individual.

Mr. FELDSTEIN. Rather than the individual. The firm is subject to the cap, so think about that now; the firm is subject to the cap. That means any individual in that firm who earns another \$100, the firm is required to send \$7.90 to the alliance.

Now, who is going to really pay that \$7.90? Not the shareholders, but the workers in that firm, the administration agrees to that. I don't think there is any issue about that. An extra \$7.90 of payment means that there is a wedge, there is a distortion, there is an extra payroll tax just like the Social Security payroll tax.

Chairman STARK. Doesn't that get paid in either plan?

Mr. FELDSTEIN. No. I mean, with what I understood to be your plan—

Chairman STARK. No, I am just saying in the President's plan, without any changes to the plan, does it make any difference whether you call that a mandated premium or a tax? You do run it through the accounts structure.

Mr. FELDSTEIN. No, if you call it a mandated premium and you have this 7.9 percent cap, then it is no different than calling it a tax and having a 7.9 percent tax.

Chairman STARK. So all we do is have a lot of semantic battles of whether I am raising your taxes or your premium. That is what I am sensing and I am not sure it is worth the battle.

Mr. FELDSTEIN. It matters for the controlled process that we talked about.

Chairman STARK. All right, but Mr. Klerman—

Mr. FELDSTEIN. It probably matters in other technical ways.

Chairman STARK. Actually, but—

Mr. FELDSTEIN. You get credits for taxes paid. Those matter in terms of international tax treaties and a variety of other—

Chairman STARK. But unions are on the hook for premium increases and not tax increases, which is why they fought calling it a tax under catastrophic. Yes, there is a lot of legalese in there, but do you want to tell me what you think, Mr. Klerman, on that?

Mr. KLERMAN. I want to repeat something that both Mr. Feldstein and I said earlier, which is that if we didn't require that we raise this thing as a premium, but raise it as a tax instead, we

could think about going to alternative mechanisms of raising the money which might not involve the distortions that Mr. Feldstein and I emphasized earlier.

Chairman STARK. There is a real fear abroad in this plan. I mean, we are jumping through hoops to avoid calling it a tax. I understand the political reasons for that, but I also have to figure, as I said earlier, what my opponents are going to call it. They are going to call it a tax, and if it doesn't make any difference to the economists, then it is up to the spin doctors to figure out what is less objectionable to the public.

Mr. FELDSTEIN. But it is true that when the press calls the economists and says is this a tax, the economists are going to say, yes, it is a tax.

Chairman STARK. If Reischauer calls it a tax, then they are in trouble.

Mr. FELDSTEIN. Mr. Reischauer is not an economist as economists define an economist. He writes about economics, but he is not an economist. He doesn't have a higher degree in economics, and that is usually the criterion by which we decide who is an economist.

Chairman STARK. Not in the White House, but go ahead.

Mr. FELDSTEIN. If they called professors of economics of both parties around the country and they said is this a tax, I think the answer they will get is, yes, this is a tax, and if they ask, as they will—who bears that tax? What happens ultimately to real income? Is it borne by the firm?

They will get the answer that Mr. Tyson said. No, it is borne by the employees. This is a tax that comes out of the employee's take-home pay, and you are going to have to discuss that with your constituents about why you decided not to call it a tax when it comes out of their—

Chairman STARK. As I say, I am prepared to defend a tax. I don't think there is a health care fairy that is going to put this money under my pillow. As I said, I think the public is a lot smarter. Ross Perot is going to get up there with a chart and show them. He controls a lot more television time than I do.

I want to thank both of you. I apologize for the spastic schedule today. We appreciate your contribution, and your testimony was very interesting, and I appreciate it. Thank you both.

Our next panel is labeled as the large businesses panel, and Jerry Jasinowski, who is the president of the National Association of Manufacturers is one member of the panel, Bernard Brennan, who is the incoming chairman of the National Retail Federation and chairman of the board of Montgomery Ward; and George Huber, who is vice president and counsel of the University of Pittsburgh Medical Center. Welcome to the committee, gentlemen, and why don't you proceed. We will make your prepared statements a part of the record. Please proceed to enlighten us in any manner you are comfortable.

Mr. Jasinowski, lead off.

STATEMENT OF JERRY J. JASINOWSKI, PRESIDENT, NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. JASINOWSKI. Thank you very much, Mr. Chairman. I appreciate that very much, and I am delighted to be here. I want to commend you, Mr. Chairman, for your longstanding interests in this issue and we look forward to working with you and other Members of the Congress on this. I don't want to say that I am on the wrong panel, but I do want to say that I don't represent big business.

We have 12,000 companies which includes all the big ones, but we also have 9,000 companies that are small, and so what is interesting about our views, I think, in part is that we represent both large and small companies. In the 6 hours we just recently debated the Clinton health care plan at our board meeting, it was a constant back and forth between large and small, and the points I am going to make, I think, therefore reflect a very thoughtful reflection of industry and manufacturing as a whole. I will make 6 points, Mr. Chairman, to summarize my statement.

Point number one, manufacturers are responsible for paying for and running much of our health care system. We spend \$60 billion a year, 97 percent of our workers are covered with good benefits, and we are making progress with respect to controlling our costs. We think we know a lot about how to run health care properly and how to improve it.

Second, we, as you and President Clinton, are totally dedicated to the objective of moving toward universal coverage and eliminating the inequities, inefficiencies and cost shifting that occurs in the current system. Some have questioned our commitment to that, but because of the cost shifting, Mr. Chairman, and because of the fact we are now paying our own way and more, we are totally committed to universal coverage in an employer-based system we would prefer, and with some shared financial responsibility for that.

My third point is that controlling cost is our most important objective, and in order to do that you really have to deal with a multifaceted set of issues that run 8 to 10 in items all the way from bringing the cost of health care to consumers' attention in terms of how they buy, the changing lifestyle, reducing the oversupply of technology and physician specialists, reforming insurance markets to reduce current uncompetitive behavior that raises cost, reducing administrative costs and transaction costs and waste in the system.

This is one of the most inefficient industries in the United States. It does not have the productivity and quality that we have in manufacturing in general, identifying and reducing inappropriate utilization and redundant care. We do an awful lot of medicine we don't need, and we ought to deal with that as well as malpractice and placing much greater emphasis on prevention and primary care.

That is just a sampling of the kind of cost control elements that we must address as we seek a bipartisan compromise here in the Congress. As I say in my statement, and I will read from it because I think it is a particularly important point on page 2.

Our members and their workers therefore have an abiding interest in the reforms that will lead to universal coverage, to an ending

of the cost shift to manufacturers, and in health care cost containment generally.

Achieving this will call for an extremely difficult balancing act. While universal coverage will reduce cost shifting initially, at some point the expense of increased coverage and expanded benefit levels will cause costs to escalate. Therefore, Mr. Chairman, you, the Members of the Congress, and ourselves all have to recognize that being for universal coverage and for cost containment can be complementary initially, but at some point it is in conflict, and that is at the essence of the debate that we must deal with, and the essence of the conflicts that we will have to resolve.

To achieve this balancing act, one of the first things you have got to do is seek an affordable benefit package, and in the resolution our board passed, we said that it was very important to have an affordable package of core benefits guaranteed to be available to all regardless of health or employment status, but a national reform plan guaranteeing such benefits must begin modestly, phasing in additional benefits only as it becomes clear we can pay for them.

While we like many aspects of President Clinton's health care package, our fundamental difference occurs with respect to the size and scope of both the cost of the program, which is partly in the benefits area, but is across the plan in general, as well as with the bureaucratic scale of it. It was our view as we said in our initial comments on it, that it ought to be dramatically scaled back.

With respect to scale, just to illustrate my point, as we indicate in our prepared statement on page 5, Mr. Chairman, this whole question of the regional alliances is a good idea in our view, but we think this has been carried too far with respect to the Clinton program. I find no justification for a 5,000-employee regional alliance.

We polled our members. Their view was, and this is because we represent both small and large, that it ought to be somewhere between 100 and 500 and that at that level we could have both adequate scale to reduce costs and bargain efficiently and that many of our firms did not feel they needed to be in regional alliances, even though they might be only a thousand in employee size.

Finally, Mr. Chairman, let me just close with my seventh point. All along, recognizing the complexity of this, we support no particular bill at this time. We wish to work with you, and I hope that you will engage me in terms of your own views on what you think we ought to do, as well as Members of the Congress on both sides of the aisle, drawing from what are the best in each plan so that we can work in agreement, which is effective for all of us.

Thank you, Mr. Chairman.

[The prepared statement and attachment follow:]

**Testimony of
Jerry J. Jasinowski, President
National Association of Manufacturers**

**On Health Care Reform and the Impact
on the Economy and Jobs**

**Before the Health Subcommittee of the
Committee on Ways and Means
U.S. House of Representatives**

November 4, 1993

Thank you, Mr. Chairman. I appreciate this opportunity to present the views of the NAM's more than 12,000 members, of which 9,000 are small companies, on the subject of comprehensive health care reform. But first, I want to commend you, Mr. Chairman, for your longstanding interest and leadership on this issue. We also commend Congressman Cooper for his bipartisan efforts in this regard, as well as the many House and Senate members of both parties who have collaborated on alternative reform proposals. And especially we commend President and Mrs. Clinton for having the courage and determination to put this issue on the national agenda.

Let me note also that American manufacturers have consistently demonstrated a broad commitment to providing their employees with good health care benefits--97% of NAM's members provide such coverage. Because we do so, manufacturers also carry a significant burden--estimated at more than \$12 billion annually--in costs that are shifted to us from other sectors. This cost-shifting occurs for a variety of reasons, including increased charges from providers who are recouping Medicare/Medicaid underpayments and the costs of serving the uninsured. Also, manufacturers pay for insuring workers' dependents who are employed in non-manufacturing sectors.

This cost-shift, and the spiraling growth of health care costs generally, cause a significant problem for U.S. based manufacturers, who have to compete in today's tough global marketplace with foreign-based firms not as extensively burdened by employment-based benefits. As several studies have shown, escalating health care costs reduce business profits in the first instance, but this is then shifted back to employees in the form of reduced

wages and employment. Our members and their workers therefore have an abiding interest in reforms that will lead to universal coverage, to an ending of the cost-shift to manufacturers and to health care cost containment generally.

Achieving this will call for an extremely difficult balancing act. While universal coverage will reduce cost-shifting, at some point the expense of increased coverage and expanded benefit levels will cause costs to escalate. In the NAM's view, a key overriding concern must therefore be controlling the overall cost of any reform plan that is adopted. Our goal must not be the best health care system that can be designed, but rather the best health care system that the country, its employers and its workers can afford.

NAM RECOMMENDATIONS

Attached at the end of my testimony, which I understand will be included in the hearing record in full, is a recently passed NAM Board resolution with recommendations on health care reform to guide the subcommittee in crafting a compromise reform plan. Broadly summarized, these recommendations urge the development of a plan that:

- Achieves universal coverage within an employment-based system; required employer participation may well be considered if the final package makes overall sense in terms of affordable benefits, sound financing, adequate employer flexibility, reasonable limits on government involvement, effective cost and quality controls, and an end to cost-shifting to business.
- Provides an affordable package of core benefits guaranteed to be available to all regardless of health or employment status; but a national reform plan guaranteeing such benefits must begin modestly, phasing in additional benefits only as it becomes clear we can pay for them.
- Motivates consumer--through cost and other incentives--to be more cost-conscious in using health care services, a big flaw in the current system; there also needs to be a major focus on reducing the need for such services through healthier lifestyles and preventive care.
- Improves the effectiveness of competitive market forces through managed competition and insurance reforms; market-based reforms should ensure that providers have incentives to deliver care efficiently, that purchasers have the ability and willingness to hold providers accountable, and that consumers have the responsibility to adopt healthy behaviors and use efficient providers.

[Examples of private sector approaches include the Business Health Care Action Group in Minnesota, the Memphis Business Group on Health, the Denver Health Care Purchasing Alliance and the Central Florida Health Care

Coalition in Orlando. In terms of statewide experience, California leads the nation in HMO penetration with nearly 85% of its population enrolled in some type of managed care, a key component of market-based reforms. California thus provides a good source of data on experiences in restructuring the economic incentives to improve the system.]

- Restricts the ability of states to impose differing requirements and systems on multi-state employers; a reformed system should continue to permit these employers to operate under a uniform federal framework (i.e., ERISA) that precludes state benefit mandates, mandatory participation in state single-payer systems, or the imposition of state taxes to fund health reform. A patchwork state-by-state system will stifle innovation in both benefit design and cost containment by multi-state employers.
- Requires meaningful federal medical liability tort reforms to discourage defensive medicine and unnecessary and inappropriate care; such reforms should include limits on non-economic damages in jury awards, stricter statutes of limitations, limits on attorneys' fees and cover liability for medical products as well.
- Ends cost-shifting to the private sector from government, to the manufacturing sector from non-manufacturing sectors and, within the manufacturing sector itself.
- Provides equitable, stable financing to assure the plan does not erode America's competitive position in the world market and does not disproportionately impact any one segment of the economy; while cuts to the growth in Medicare and Medicaid spending will yield some revenue to finance health reform, excessive dependence on such cutbacks as a major funding source has the potential to exacerbate cost-shifting to the private sector.
- Avoids establishing powerful and potentially overreaching national or regional bureaucracies, such as the Administration's plan for a network of huge regional alliances, coupled with a national health board and special purpose oversight committees.

COMMENTS ON REFORM PROPOSALS

I want to illustrate how one or two of the foregoing principles apply. But first let me comment generally on the variety of reform plans that have been advanced to date. In addition to the President's plan, the first comprehensive effort to be fully unveiled, Congressman Cooper, Senator Chafee and other House and Senate members have developed plans worthy of detailed consideration. Because details of the President's plan were more completely available, our attached board resolution identifies at some length both the

perceived strengths and weaknesses of that plan. The resolution's eleven recommendations, however, have been drafted as standards by which any reform plan should be examined. We are concerned, for example, not just with what we see as the overly ambitious scale and cost of the Administration's plan, but with the potential scale and cost of any plan that is adopted.

Let me illustrate. Several of the plans under consideration would use purchasing groups or alliances to give small businesses and individuals access to affordable coverage. This is, in our view, a pretty good idea. In the case of the Administration's plan, however, all employers having fewer than 5,000 workers would be forced into these state-regulated regional alliances. This is an example of a good idea carried much too far. Many firms much smaller than this are already--through a combination of employee education and creative benefit design and cost containment techniques--providing benefits as good as or better than those proposed in the Administration plan at a lower cost. This is clearly something we don't want to discourage.

In a recent survey of our board, 97% believed that the 5,000 employee threshold was too high. 81% of these directors felt the threshold should be 500 or less. Based on the original idea that the purchasing groups should help small companies band together to purchase health care, our judgment is that the group should be limited to between 100 and 500 employers. Congressman Cooper's proposal would, for example, only require firms with fewer than 100 workers to join a regional alliance.

Let me turn briefly to the issue of making consumers better buyers and more cost-conscious in their utilization and selection of health care services. The NAM regards this as particularly important because much of the increase in health care costs is demand-driven and adding 37 million uninsureds to the system will significantly increase demand. Moreover, there is a need for cost containment generally and experience has shown that consumers are sensitive to price increases that impact them directly. We therefore believe that any plan adopted must stress consumer participation through at least partial responsibility for premiums and through deductibles, co-payments and other techniques. Education about choices and wellness are also essential. There may even be merit in considering a cap on the amount of employer-paid health coverage that can be received tax-free by the employee.

SOME ECONOMIC OBSERVATIONS

To be sure, the impact of reform is likely to be multi-faceted. On the plus side, firms now providing coverage, particularly those covering working spouses, may see diminished costs. Portability of coverage should foster job mobility and reduce "job lock" that will enhance labor productivity and employee satisfaction. The costs of corporate restructuring might diminish, since firms may have the option of placing employees in regional alliances. Relieving employers of primary responsibility for early retiree coverage would help certain industries with a heavy concentration of older workers. Reducing the rate of health care cost increases over time will help free up resources to invest in research and development,

training/re-training, modernization of plant and equipment, etc.

Let me now make five specific fundamental observations about health care cost inflation and employment effects:

(1) **Excess Demand.** A major cause of health care inflation has to do with excess demand for health care services. The demand-pull process originates in the fact that consumers do not have to pay the actual cost of their health care, but only a contribution to an employer-provided insurance plan. Expressed another way, individuals in the aggregate demand more medical care than is needed because of the third-party payer system and the constant proliferation of new products and technologies.

(2) **Consumer Cost-Sharing and Incentives.** The demand-led aspects of health care inflation should make policy makers cautious about enacting an excessively generous benefit package, since this will inevitably stimulate additional spending and put further pressure on prices and costs. In this respect, consideration should be given to major cost-sharing by consumers. Any number of studies have documented that the consumer response to out-of-pocket costs is substantial. By implication, the most effective way in which excess demand for health care can be dampened is to increase the component paid directly by the consumer, e.g., through higher employee co-payments or deductibles.

(3) **Additional Cost Pressures.** There is also a cost-push element of health care inflation. The cost component in medical inflation is determined in part by technological advance. In essence, new technologies enable the sector to provide more services, and the demand for these services enables the suppliers to incorporate the cost of technological advance into the sale price. There are several other components on the cost side, such as waste in the system, excessive bureaucratization, defensive medicine, excessive legal costs, and inappropriate care. Substantial segments of the health care and insurance industry have been able to pass these costs forward in higher prices because of a lack of competition. In other words, components of this sector possesses enough market power to engage in administered pricing. For this reason, Congress should adopt a managed competition approach to strengthen market competition and reduce the ability of the health care sector to mark these costs up into prices.

(4) **Impact on Employment.** The cost of health insurance to employers is generally shifted back to workers, either in the form of decreased wages or diminished employment. According to RAND Corporation estimates, payments by businesses for health insurance on behalf of their employees are currently in the range of \$218 billion. Particularly in the manufacturing sector, which has been exposed to unprecedented foreign competition over the last decade, these costs cannot be passed forward to prices. Instead, the health insurance costs imply a decline in profit margins. In order to cut costs and restore profitability, firms often shift the costs back to workers either by reducing wage gains or by lowering employment.

A 1992 MIT study and a 1991 Wharton School study in which we participated both found that increased medical costs often show up as reductions in wages, decreases in employment, and decreases in hours worked. The pressure on margins from non-wage costs such as health insurance is one contributing factor to the decline in manufacturing employment since 1979. The implication is that Congress should be cautious about expensive increases in benefits paid for by private employers, since these simply increase costs per worker.

(5) **Health Care and Job Losses.** A mandate on employers would entail some increased labor costs and job losses, particularly at the low end of the income scale. Because of the minimum wage, at this level wage cuts cannot be substituted for benefit costs, with the result that the costs are likely to show up as diminished employment. This will in part be offset by the cut in health care costs for large manufacturing firms, implying lower labor costs and higher employment in some industries. Nevertheless, Congress should be aware of the risk of job losses as it fashions a comprehensive health package.

CONCLUSION

Let me conclude by noting that NAM does not at this time support any of the alternative health care reform plans now under consideration. Nor do we oppose any of them, at least not those that would continue the current employment-based approach. It is much too early in the debate, in my judgment, to make any sweeping statements of support or opposition to any particular legislation. Instead, we think the Congress needs to evaluate--and then draw what is best from--all these plans, and forge a bipartisan compromise on a plan that is best for the U.S. The NAM stands ready to assist in this effort.

NATIONAL ASSOCIATION OF MANUFACTURERS
BOARD OF DIRECTORS MEETING
Los Angeles, California
Approved October 9, 1993

Resolution on Health Care Reform

American manufacturers have consistently demonstrated a broad commitment to providing employees and their families with good health care benefits. We therefore have a vested interest in the current debate over how best to reform the U.S. health care system. The Administration has presented a comprehensive plan for addressing this challenge, and a number of other constructive proposals for major systemic reform have been developed by members of Congress. The National Association of Manufacturers is working with the Administration and the Congress to shape a bipartisan reform plan that is right for the United States and that has, as major goals, reducing health care costs as a percentage of Gross Domestic Product and making U.S. firms more competitive in world markets. To guide this process, we offer--subject to the caution that these are preliminary views that may change as more specific details become known--the NAM's assessment of the Administration plan:

Positive Aspects

- Establishes the principle of shared employer and individual financial responsibility for moving towards universal access within an employment-based health care system.
- Proposes insurance market reforms that would assure Americans they will not lose health coverage due to changes in health or employment status, and that would improve the availability and affordability of health coverage to small businesses.
- Provides for regional purchasing alliances as a means to assist small firms and individuals in obtaining affordable coverage.
- Attempts to address the need for cost containment as well as for reductions in the excessive administrative costs that pervade the health care system.
- Focuses on the need to improve the quality of health care through enhanced consumer access to information on provider performance, which should help reduce unnecessary and inappropriate care.
- Recognizes that the cost of coverage for early retirees negatively affects many U.S. companies and their ability to compete in international markets.

Negative Aspects

- Advocates an overly generous package of guaranteed benefits far beyond what the nation can afford.

- Relies on a narrow, probably diminishing tax base and on very ambitious Medicare/Medicaid savings goals that could perpetuate cost-shifting to the private sector. Moreover, the plan fails to deal comprehensively and evenly with the multifaceted cost-shifting problem.
- Undermines, for multi-state employers, the existing federal framework (ERISA) that precludes state mandates, participation in single-payer systems and the imposition of state taxes and state data requirements.
- Sets an inappropriate 5,000 employee threshold below which employers would be forced to join regional health alliances, placing nearly 71% of U.S. workers into such publicly-sponsored entities and forcing many smaller employers, who individually or through groups have initiated cost-effective quality health care arrangements, to join these regional alliances at substantially higher cost.
- Provides excessive restrictions on those employers who would be allowed to operate their own corporate alliances, imposing potentially unjustified cost increases and unreasonable limits on innovative benefit designs and cost containment techniques.
- Creates cost controls and overreaching regulatory structures that conflict with the goal of reducing administrative costs and of making health care markets more competitive, while putting insufficient emphasis on the need to make consumers of health care services more cost-conscious.
- Does not adequately address medical liability tort reform.

We appreciate the Administration's recognition that its health care reform plan will undergo a series of revisions as it moves through the legislative process. As Congress considers the Administration plan together with competing Congressional plans, the NAM urges that its deliberations be guided by the following recommendations:

1. Guaranteed Benefits Package. The guaranteed benefit package must be significantly trimmed. The plain fact is that we cannot afford to provide, over and above a basic package of core benefits, a long list of expensive additional coverages. Such coverages should be added, if at all, only later after it is clear they are affordable. Benefits and costs should be tied together.

2. Cost-Shifting. Any approach to ending cost-shifting must simultaneously address all the different types of cost-shifting that occur, which includes cost shifts to the private sector from government, to the manufacturing sector from non-manufacturing sectors and, within the manufacturing sector itself, to firms whose health plans are cost-effectively managed from inefficient plans.

3. Multi-State Employers/ERISA. Any reformed system should continue to permit multi-state employers to operate under a uniform federal framework (i.e., ERISA) that precludes

state benefit mandates, mandatory participation in state single-payer systems, and the imposition of special state data requirements or state taxes to fund health reform.

4. Regional Alliances. The general concept of regional alliances as purchasing cooperatives that enable small firms and individuals to obtain affordable health coverage is a sound one. The 5,000 employee threshold, below which joining an alliance would be mandatory, is much too high and should be dramatically reduced. Consideration should also be given to allowing employers with fewer than the threshold number of employees the option of acquiring health coverage through group plans sponsored by unions, employer associations and other non-profit organizations.

5. Corporate Alliances. The rules for corporate alliances should be less regulatory and bureaucratic, so as not to stifle innovation in both benefit design and cost containment, and neither excessive reserve requirements nor unjustified surcharges should be imposed.

6. Consumer Education and Participation. Any reform plan must include a major focus on giving consumers of health care services sufficient incentives to be more cost-conscious in their selection and utilization of such services and, just as importantly, to reduce the need for such services through healthier lifestyles and greater emphasis on preventive care.

7. Market Forces vs. Regulation. Since it is unclear that premium controls will work, increased emphasis should be placed on market-oriented approaches, such as incentives for Medicare beneficiaries to switch to managed care networks. As a general rule for approaching cost containment, targets are preferred to direct controls.

8. Excessive Bureaucratic Structures. Any reform plan should avoid establishing powerful and potentially overreaching national or regional bureaucracies such as the Administration's plan for a network of huge regional alliances, coupled with a national board and accompanied by special purpose oversight committees.

9. Required Employer Participation. This may well be considered if the final package emerging from Congress makes overall sense in terms of affordable benefits, sound financing, adequate employer flexibility, reasonable limits on government intrusiveness, effective cost and quality controls, and an end to cost-shifting to business.

10. Medical Liability Tort Reform. Strong medical liability tort reforms are needed, and should include limits on non-economic damages in jury awards, stricter statutes of limitations and limits on attorneys' fees. The scope of such reforms should include liability for medical products.

11. Integration of Workers' Compensation. Any changes including workers' compensation medical services in a reformed health care system must lead to overall financial savings for employers that presently provide both.

Chairman STARK. Thank you.
Mr. Brennan.

STATEMENT OF BERNARD F. BRENNAN, INCOMING CHAIRMAN, NATIONAL RETAIL FEDERATION, AND CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER, MONTGOMERY WARD & CO.

Mr. BRENNAN. Thank you, Mr. Chairman. My name is Bernard F. Brennan. I am the chairman and CEO of Montgomery Ward and the incoming chairman of the National Retail Federation. I would like to thank you for the opportunity to testify today on behalf of the National Retail Federation concerning the impact of the administration's health care plan on the economy and jobs.

First of all, Montgomery Ward is a company of 60,000 employees. We offer comprehensive health care to all full-time employees and part-time employees working over 30 hours per week. We have a history of supporting health care dating back to 1912 when Montgomery Ward was the first company in America to offer health care to its employees.

We support health care on this basis: We support covering those who do not have health care, those who cannot afford it, those without or between jobs, and those with preexisting conditions. We support controlling runaway costs and we support reducing bureaucracy.

Let me describe the retail industry very briefly: We employ 20 million people. One out of every five American workers are employed in the retail industry. We create a significant number of jobs outside of retailing to support the industry itself. It is important to note that 25 percent of those recently unemployed in America find new jobs in the retail industry. There is a lot of transition. We create 300,000 jobs each year.

Retailing is a total service industry. We are open from 12 to 24 hours a day, we are open 7 days a week, and, of course, therefore, we employ massive numbers of part-time employees.

Who are the employees in the retail industry? Millions of hard-working, dedicated, full-time employees, many Americans who want second jobs, senior citizens looking to remain active, young people working to save for education and other needs. So we believe in health care reform, but the result of the administration's plan in our mind would be huge increases in costs and potential losses in jobs.

Now, I would like to give you the results of a survey of 10 retailers employing 1.3 million employees which was just conducted. It shows that the first year cost for health care could rise an average of 89 percent, until the 7.9 percent cap is fully phased in. Even with the 7.9 percent cap phased in, costs would increase up to 40 percent for employers in regional alliances.

Finally, retailers in corporate alliances would see average increases of 98 percent, and some as high as 190 percent, so corporate alliances are not viable for retail companies. Retailing is labor intensive. It is a low margin industry that cannot absorb these costs. We are highly competitive. We operate on very thin margins.

Since 1990, 50,000 retail companies have filed for bankruptcy in this country and 43 of the top 100 department store chains in 1980 are no longer in business.

The issue is productivity, and productivity data underscore the potential impact that the plan would have on retailing. That is set forth on page 3 of my statement. Each full-time retail employee produces \$1,750 a year in corporate earnings, compared to \$6,500 earned in manufacturing. So each retail employee produces corporate earnings of \$1,750 versus \$6,500 per manufacturing employee. To say it another way, it takes 3.7 times more retail employees to produce the same profit as one manufacturing employee. That is the issue for our industry. The cost of the administration's health care plan would be 83 percent of our corporate earnings for individual coverage. When you get to a family coverage, the cost would be more than double our corporate earnings per employee, so the issue is this: We would have to commit substantially more of our earnings per employee to carry an even heavier burden than we carry today, and under the administration plan, as an industry we would carry a much heavier burden in terms of an employee's contribution to retail earnings than does manufacturing. So to summarize, the basic concern is jobs.

The retail industry creates and plans to continue to create new jobs in the marketplace. I mentioned we create 300,000 new jobs per year, but our preliminary estimate shows that we could lose 500,000 jobs based upon the administration plan. If you look at it another way and remember that there are 20 million people employed in retailing, a 5 percent reduction alone would be 1 million employees.

Chairman STARK. Let me try this on you, Mr. Brennan. I am aware of your program. Just to use your numbers, I would hope it wouldn't be this high, but if I translated that and said, all right, what if we said to you we will change that to 72 cents an hour.

Now, that means you have to pay it. If you pay more for your executives, that is your business. The Gap in the same mall has to pay 72 cents an hour. And then we will get the guy on the street with the card table, when he goes to the emergency room.

Mr. BRENNAN. He would be under the lower cap. He would be at 3.5 or 4 percent.

Chairman STARK. I am just saying if we changed the plan, and just said that everybody who is above a certain poverty level pays. Let's say we translated your figure of 1,440 to just so much an hour, somebody works 5 hours, they come in for Christmas, they only work 2 weeks, they only work 10 hours a day. During that period would that make it easier for you?

Mr. BRENNAN. No. The issue is if you take 80 cents, you take 80 cents times the number of employees we have, which is 60,000 times 1,560 hours, that is \$75 million a year. Our company earns \$100 million a year, and we are—can I just finish my point.

Chairman STARK. I assume this gets passed on to prices for your customers, but your competitors are all in the same position. In a sense, it is a minimum wage increase. For those employees for whom you are already paying insurance, there would be no increase, but for those that you are not, you would be paying 72 cents an hour more, so would all your competitors across the country.

Wouldn't that be easier on you than the percentage plan?

Mr. BRENNAN. Well, if I could respond to the first point, if you look at the retail industry, again it is a very low margin industry, and its margins have gotten lower over the last few years. In the last 3 years we have had 50,000 retail companies file for bankruptcy. In the decade of the 1980s we had retail square footage grow by 60 percent, and the population by 10 percent. What does that mean?

It means there is deflation, there is actual deflation in general merchandise product, so the premise that we can raise costs and have parity and have every retailer absorb those costs I really don't think is realistic. Trends don't point that way.

Chairman STARK. Are you then telling me that the retail industry just can't pay anything for health insurance?

Mr. BRENNAN. I am saying that the retail industry is labor intensive, that it is low margin, and it is low wage. I just want to reiterate that.

Chairman STARK. I understand.

Mr. BRENNAN. And that its health care payment per employee against its income per employee are among the highest in America. The challenge is a simple one. We hire a lot of people who are looking for second jobs, who are out of jobs. I would guess that most of the people in this room have worked in a retail store at some time in their lives, so most people understand the economic issue.

Chairman STARK. I understand that, but you are saying that there is no way the retail industry can pay anything, particularly for part-timers who are principally those who are uninsured in the retail business. Most full-time employees get some coverage. If you are saying that, no, you can't pay, you have got to make the case that therefore the food and beverage industry shouldn't pay, either, because they also have a huge number of part-time employees. They also create a lot of jobs, while at the same time, they have a lot of bankruptcy.

I don't know where we would go next, but you see very quickly where we end up is we don't have employers contributing for the part-time workers, and if that happens, then when we heard the two economists who preceded you, there are going to be a whole hell of a lot of hurt employment agencies out there renting you employees to avoid that, and so I have to come back and say how can you contribute?

What is the easiest for you to contribute toward those part-time employees who are essential not only to your industry but to the food and beverage industry, or to the lodging industry.

Now, I am saying that I think that the least disruptive method for you is to pay so much per hour for the hours they work, understanding that you have to pass that through. That obviously goes on the price of that good looking suit you are wearing that you bought at Montgomery Ward.

Mr. BRENNAN. Thank you, I am glad you noticed that.

Chairman STARK. What I am saying is it goes from \$295 to \$315 except if I get it on sale. So the other side of the coin is you feel better because you know everybody working there has health insurance. Now, is that the easiest way if you have to swallow some of the cost to do it on a per-hour basis at a fixed rate?

Mr. BRENNAN. Well, when you get to the per-hour basis, the lower the wage, the higher the percentage. If you take your example, you would be talking in the area of a 15 percent impact on that associate. I guess I would like to go back to my first comment, if I could, and then respond, and that is that we believe in health care reform. We believe in offering health care to those who do not have health care.

We believe in offering health care to those who are between jobs and those who have preexisting conditions. We do not believe in beginning with, starting with mandated health care to achieve those objectives, so if I can go back.

Chairman STARK. You lost me there. I am afraid the President's plan, and I buy on with this, that there isn't a lot I like in it, but we are saying guaranteed. There is that word in there that every—he is saying citizen, I am saying resident—every citizen will be guaranteed coverage and access regardless of the status of their health or their pocketbook, and now he is suggesting that since probably 70 percent of that care now, for those who have insurance, comes through their employment for the most part. But you unfortunately, having a lot of part-time workers, are one that gets hit with an increase, I recognize that. But Nordstrom gets hit worse.

They are much worse than you are in their employee—

Mr. BRENNER. Who is?

Chairman STARK. Nordstrom. They are awful in their employee relations. You guys are excellent. Nordstrom is really bad.

Mr. BRENNAN. Thank you.

Chairman STARK. But everybody is going to get hit. So is McDonald's. The big food companies are going to get hit, Marriott as well, and all other service industries. Mr. Jasinowski's members have a far broader coverage and not quite so many part-time workers as the service industries. You are different. He doesn't get hit as hard, and I recognize it.

Now, I can't figure out how we let you out of the box, quite frankly, because other people will say we want to be out, too, and then this whole plan unravels. If you are not prepared to answer today it would be helpful to us sometime in the future. I think the least objectionable way is to say so much an hour, like a raise in minimum wage and keep it as low as we can.

I don't want you to name your own poison, but that is what I am pushing at here, and you may not be prepared to deal with that today, but given that, we will continue to be an employment based system.

Mr. BRENNAN. The point I made earlier on is that we are self-insured, we have cost-control incentives, and we have lowered the increased rate of health care cost below the rate for other companies and industries. The disincentives in a government-controlled plan are a problem, involving how many dollars or how many cents can we tag on to each employee. I guess I would rather go back and talk about the plan itself—what we think some of the flaws are in the plan—and then talk about remedies to the plan.

I guess you are further down the road and I understand that. The plan is moving along. But I really can't start at the same point as you can.

Chairman STARK. I am saying whatever the plan is, there is going to be some costs to employers who do not now provide insurance to a certain segment of employees. I recognize in the service industries in general that we have a much higher percentage of part-time workers and therefore the way the plan is presented by the President is pretty tough on you.

What I am trying to find is a way to lighten that load, and that is regardless of what the plan is.

Mr. BRENNAN. Let me make one suggestion, if I can, that was discussed with the administration. Early on in our discussions with the administration we talked about the same program or a similar program the administration has proposed for small business.

In other words, if you have someone making \$11,000 a year, they would be capped at a certain rate, versus just a 7.9 percent overall cap. We have had discussions, and I would be happy to come back and talk about the alternatives. I think the point I would like to make, though, if I could, is that from what I can understand about the administration plan today, we don't understand what the phase-in period is and we don't even know when the 7.9 percent cap starts, and you can interpret it many different ways.

Chairman STARK. You can't afford the President's plan.

Mr. BRENNAN. Clearly.

Chairman STARK. I agree.

Mr. BRENNAN. So we would like to work with you on recommendations because we just can't—

Chairman STARK. Mr. Fisher probably won't like hearing this. He probably can, but I haven't showed him how yet.

Mr. BRENNAN. I think he might like to hear from you.

Chairman STARK. You have the same problem, but he has a different work force, a little bit different.

Mr. BRENNAN. He has a slightly higher part-time work force than we have. We are on the same committee and we share the same numbers.

Chairman STARK. I am sorry to interrupt.

Mr. BRENNAN. No, that is fine. In fact, basically where I am is what we just discussed, and that is that we support health care reform. We support providing health care to those that don't have it, but we are labor intensive, low wage, and low margin. We have an enormous problem in the potential risk of losing 1 million jobs. It is a very simple comment. Thank you.

[The prepared statement follows:]

NATIONAL RETAIL FEDERATION

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STATEMENT OF BERNARD F. BRENNAN ON BEHALF OF THE NATIONAL RETAIL FEDERATION

CHAIRMAN OF THE BOARD AND CEO,
MONTGOMERY WARD AND CO.

BEFORE THE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH

NOVEMBER 4, 1993

Chairman Stark, Mr. Thomas and distinguished Members of this Subcommittee, my name is Bernard F. Brennan. I am Chairman of the Board and CEO of Montgomery Ward and Co. and incoming Chairman of the National Retail Federation (NRF). I appreciate the opportunity to testify today on behalf of NRF and to present Montgomery Ward's views on the impact of the President's health reform plan on the economy and jobs.

A company with 60,000 employees, Montgomery Ward today offers a comprehensive health care plan to all of our full-time employees and part-time employees working over 30 hours a week.

Montgomery Ward established a milestone in 1912 when it became the first company in American business to offer health care coverage to its employees. We are proud today to be in the forefront of the debate about how best to overhaul the nation's health care system. Montgomery Ward and the entire retail industry share the President's vision of quality, affordable health care for all Americans.

We support health care reform that seeks to achieve the following goals:

- Access to coverage for those without health care, including those who cannot afford it, those without jobs, and those with pre-existing health problems;
- Control of runaway health care costs; and
- Reduction of the health care bureaucracy that burdens the health care system.

We believe that these objectives can be attained without massive disruption to labor-intensive, low-margin industries such as retailing and the resulting impact on the American economy.

Retail Industry

To succeed, however, we believe that a health care reform plan must take into account the unique size, function and economics of retailing. Retailers employ 20 million people, 20 percent of the U.S. workforce -- one in five workers. The retail industry is an engine which drives new job creation in the United States. Retail job creation causes both a productivity and economic ripple effect. Every \$1 million in retail sales creates many more jobs outside of retailing -- in manufacturing, transportation and other sectors. Fully 25 percent of the recently unemployed obtain new jobs in retailing. Retailing contributes to our nation's vitality by generating over 300,000 new jobs each year for the past two decades.

The job of retailing is to serve its customers. Many retailers -- like my company -- are open seven days a week, 11 to 12 hours a day (some even 24 hours a day) to accommodate the changing life styles of our customers today. That schedule requires a very flexible work force, including large numbers of part-time and seasonal workers. In addition, peak buying periods define much of the business. Retailing consistently creates jobs to meet its unique needs.

Companies like Montgomery Ward and other large and small retailers provide the jobs which make ends meet for millions more part-timers who are single parents and need flexible schedules; older workers who want to keep active; teenagers getting a first job after school and their first taste of the working world; and college students working to contribute to their educational expenses.

A recent study by an independent economic consulting firm confirmed that 73 percent of part-time employees choose to work part-time. Many work to supplement family income. They include working mothers, students, teachers, and others who do not want full-time employment. Recent studies also show that approximately 50 percent of part-time workers currently receive health insurance coverage under a family member's or spouse's insurance plan. Also, many part-time employees such as teachers hold a primary job and receive health coverage from the employer.

Financial Impact on Retail Industry

We wish to express today our concern about the adverse effect of the Administration's health care plan on retailers. The continued ability of Montgomery Ward and other U.S. retailers to create jobs and to contribute to national economic prosperity would be threatened by the massive new costs the Administration's health care plan would place on employers. While we agree that health care reform is very important, the retail industry believes that such reform must be achieved without sacrificing hundreds of thousands of retail jobs. A survey of ten retailers employing 1.3 million employees shows that first-year health care costs could rise an average of 89 percent until the 7.9 percent cap is fully phased in. Even at the end of the phase-in period, the increase would be in excess of 40 percent for retailers joining a Regional Alliance. For a Corporate Alliance employer, the average cost would increase by 98 percent, and several would see increases in the range of 100 percent to 190 percent. (The survey was conducted by the National Retail Federation in conjunction with TPF&C, an independent employee benefits actuary.)

The retail industry differs substantially from the traditional manufacturing model. Because retailing is labor-intensive and has low profit margins and low productivity, the industry cannot absorb these massive cost increases.

Retailing is highly labor-intensive and highly competitive. Its profit margins are very thin. Since 1990 alone, over 50,000 retailers have gone bankrupt. Forty-three of the top 100 department stores operating in 1980 are no longer in business.

Productivity data underscores why the Administration plan has disastrous consequences for the retail industry. A full-time equivalent retail employee produces \$1,740 in corporate earnings while a full-time manufacturing employee produces \$6,447 in corporate earnings. Thus, on average, it takes over 3.7 retail employees to equal the productivity of a single manufacturing employee. The chart below illustrates our productivity concerns.

Productivity and Health Care Costs In Retailing Compared with Manufacturing

	Annual Corporate Earnings Per Full-Time Employee*	Employer Cost of Individual Health Care	Cost of Individual Health Care As Percent Of Earnings	Employer Cost of Family Health Care	Cost of Family Health Care As Percent Of Earnings**
Retailing	\$1,740	\$1,440	82.8%***	\$3,360	193.1%***
Manufacturing	\$6,447	\$1,440	22.3%	\$3,360	51.1%***

* Source of data: "Survey of Current Business," August 1993, Bureau of Economic Analysis, U.S. Department of Commerce.

** Estimated Administration plan's individual coverage cost is \$1,800 per year. Employers would be required to pay 80 percent or \$1,440. Family coverage would cost \$4,200 per year, costing employers 80 percent or \$3,360. (Family cost can vary depending on the number of working family members in the Regional Alliance.) After the payroll cap is phased-in, a Regional Alliance employer would pay \$1,375 based on 7.9% of average retail worker earnings.

*** Assumes coverage under Corporate Alliance or until 7.9% cap is phased in.

Under the Administration's health care plan, employers would pay 80 percent of the premium cost of \$1,800 per year for single coverage. That cost would be \$1,440, or 83 percent of what a full-time retail employee produces in earnings. Eighty percent of family coverage, at \$4,200 per year, would cost \$3,360 -- nearly double what a full-time retail employee produces in earnings. The cost/earnings difference for part-time workers would be even greater.

Significant differences exist in company annual corporate earnings per full-time employee. The labor-intensive retail industry, with its low profit margins and wage base, would be forced to absorb an imbalanced and disproportionately high percentage of costs to underwrite the coverage envisioned under the Administration's plan. We urge Congress to creatively and carefully think through the economic implications of charging ahead with this plan despite the productivity, employment and economic implications.

A mandate requiring employers to pay their employees' health insurance expenses translates directly into increased labor costs for business. The reality is that the hardest hit sectors of the economy will be small firms and labor-intensive industries with high concentrations of lower-wage workers -- such as the retail industry.

Our experts advise us that retailers should anticipate that their health care costs will double or possibly triple. We fear not only the costs, but also enlarged and costly new administrative burdens. Unlike higher-wage industries which may be able to shift forms of compensation to reflect greater health care costs, the retail industry cannot shift the increased labor costs imposed by a mandate.

Potential for Massive Job Loss

The retail industry has increased and plans to continue to increase employment. But the fundamental economic truth is that with lower-wage jobs the only way to reduce labor costs is to reduce labor. Thus in business where labor costs are a large portion of overall costs, the effect will inevitably be massive job losses.

Realistically, retailers would be forced to respond by cutting jobs. Preliminary estimates indicate that at least 500,000 retail jobs would be affected. Other research suggests that number could be substantially larger. A modest cut of 5 percent in the current retail work force of 20 million would affect 1 million employees. When considering the multiplier effect on non-retail support industries, the impact on the American economy could be well in excess of one million jobs.

It is unrealistic to believe that the Administration's health reform plan could be accomplished without a significant realignment of the retail workforce. That realignment will dictate eliminating jobs, rethinking temporary jobs and severe cutbacks both on new positions and wage increases. Retailers would lose needed scheduling flexibility while workers could lose job opportunities. Many more retail locations would become unprofitable or marginal operations and subject to closure. The Administration has downplayed to date the fact that the health care reform plan could cause serious problems in the labor market and has highlighted alleged safeguards for various segments of business. It is imperative that Congress carefully focus upon the realignments of the workforce and significant job losses that would occur out of economic necessity under the Administration's health reform plan.

The Administration's health care plan also would adversely affect retail workers and businesses by eliminating an employee's choice to be covered under the employee's company plan.

The disincentives in the Administration's plan would, if retained, force the retail industry and Montgomery Ward to discontinue its corporate health benefit plans and place its employees in regional governmental alliances. These include a 1% payroll tax, a contribution rate of up to 95%, and the loss of a 7.9% payroll cap under a corporate alliance.

We in retailing believe that we can manage health care plans far more efficiently than would governmental-sponsored alliances. We also believe we can control costs effectively because our health care plans provide incentives to employees to spend health care dollars carefully.

Conclusion

Montgomery Ward and the National Retail Federation want to work with Congress and the Administration to achieve health care reform. We want to grow jobs and have done so historically. However, the labor-intensive, low-margin retail industry cannot be measured on the same basis as capital intensive industries. As I have explained, the contribution to earnings of full-time equivalent retail employees is substantially less than the contribution in other industries. Remember, under the Administration's plan, retail employers would pay 80% of the premium cost of \$1,800 for single coverage, or \$1,440. This is 83% of what a full-time retail employee produces in earnings. Eighty percent of family coverage at \$4,200 per year would cost \$3,360. This is nearly double what a full-time retail employee produces in earnings. When you consider that 3.7 full-time retail employees generate the same contribution to earnings as one manufacturing employee, retailers, by covering their full-time and many part-time employees, actually commit significantly more of their earnings to health care per employee than do manufacturers.

The high costs of health care reform cannot be absorbed unfairly by the retail industry in a manner that undermines the individuals and families we all want to serve through health system changes. Since 1979, the retail industry has created 3.4 million jobs (Bureau of Economic Analysis, Department of Commerce), and now the Administration's health care plan creates the risk of loss of hundreds of thousands, perhaps a million jobs.

As an employer who views with pride our historical legacy as the first American company to offer health care coverage to our employees in 1912, and as a concerned industry, we want to continue to meet the needs of the workers and the consumers we serve, and we look forward to working with Congress to achieve the goal of universal access while addressing the critical issues raised today.

Chairman STARK. I would like to recognize my distinguished colleague from Pennsylvania to introduce the next witness and let him take the Chair. The Chair has to excuse himself.

Mr. Coyne.

Mr. COYNE [presiding]. Thank you, Mr. Chairman.

I want to take this opportunity to welcome George Huber, one of the outstanding medical care administrators in my district, which is Pittsburgh, a region that has over 108,000 workers who are connected to the medical industry, roughly 12 percent of our work force. Pittsburgh is not unusual in the fact that a good amount of the economy depends on health care. Other metropolitan cities such as Baltimore and Detroit have developed health care as major industries in their region as well.

As I mentioned to Health and Human Services Secretary Shalala when she testified here before the committee last month, the Pittsburgh region has over 20 top notch hospitals. I am concerned about the impact any health care reform package will have on those institutions and the individuals who they employ. I am sure my colleagues share my concerns as well.

The University of Pittsburgh Medical Center which Mr. Huber represents here today is in a unique position in that it is a primary source of health care delivery in the region, and it is the largest private employer of the area with 12,000 employees. I thought their comments here today would be particularly insightful. On October 3 of this year the New York Times ran an article about the impact and influence of the health care industry in the Pittsburgh economy, and I would like to submit that article for the record.

[The information follows:]

REBUILT PITTSBURGH ECONOMY BRACES FOR NEW BLOW UNDER A U.S. HEALTH PLAN

By MICHAEL DeCOURCY HINDS

Special to The New York Times

PITTSBURGH — This city may always be known as Steel Town, but Medicine City would more accurately describe its economy today.

Health care became the dominant industry here after global competition wiped out most of the area's steel mills in the early 1980's. The health industry's steady growth, adding about 4,000 jobs a year in the last decade, helped revive the economy. The local hospitals have a worldwide reputation for transplant surgery and high-technology medicine.

Now, the prospect of a new national health care system is seen as a threat to the economic foundation of a region that has nearly as many magnetic resonance imaging X-ray devices all of Canada. The new system will challenge an industry that economists say has too many hospitals, too many administrators and too many staff members.

The health care industry buoys the local economy by providing nearly 1 of every 8 jobs and by generating \$3.8 billion a year, or about 9 percent of the region's total spending.

11.8% in Health Care

Though Pittsburgh's economy is far from alone in its dependence on the medical industry, it is vulnerable because the region has 108,000 health workers, or 11.8 percent of its total work force in July, according to the Bureau of Labor Statistics. No other metropolitan area has such a high proportion of health workers.

If the Clinton health plan is approved and if it works as advertised, Pittsburgh's growth will stall, economists say, as its health industry becomes more efficient. The question is what will happen over the long term.

"It's clear that the health care sector here will not be a major source of growth in the future, if the Clinton plan goes as it is," said Judith R. Lave, a professor of health economics at the University of Pittsburgh. "It will be hard for Pittsburgh to adjust, but I don't think it's all gloom and doom."

As hospitals shed beds, thousands of jobs go with them. But some health economists expect that the loss of hospital jobs will be largely offset by increasing employment in the growing

health sectors like home care, nursing homes and suburban clinics.

5-Year Stall Predicted

Nearly 15 percent of the region's 2.1 million residents lack health insurance. As these people obtain coverage, they will increase demand for primary and preventive services, said Margaret A. Potter, associate director of the Health Policy Institute at the University of Pittsburgh.

And because the Pittsburgh region has the nation's second-oldest population of any in the country, after Miami, economists predict that the elderly's need for health care here will continue to rise slowly through the year 2030, even as Pittsburgh's population declines.

"My gut feeling is that health care will stop adding jobs for a five-year transition period, when some job

shrinkage will occur, and then jobs would start to grow again," said Paul R. Flora, regional economist for the PNC Bank Corporation here.

Many health care workers already face a revolving job market. Last December, for example, Denise Kovach lost her job as a registered nurse at Forbes Metropolitan Hospital in Pittsburgh. "You can't take a job and think it's going to last forever anymore," said Ms. Kovach, 43.

The hospital, concerned about its future in a crowded market, converted from a 175-bed general hospital to a 121-bed institution serving only convalescing patients, said Dawn M. Gideon, a senior vice president with the Forbes Health System, which runs the hospital. She said the hospital laid off 292 of its 668 employees, but in March rehired 60 of them, including Ms. Kovach, as well as 40 new employees, when the transition was completed.

Support for Clinton Plan

Hospital officials here said in interviews that they generally supported the Clinton plan, despite the spending reductions it promises. Many said the plan would accelerate some industry

trends already under way.

"We believe that the plan has been pretty much anticipated, and our overall view of it is quite positive," said Jack C. Robinette, president of the Hospital Council of Western Pennsylvania.

Hospitals here are converting wards to outpatient services from outpatient ones, opening up suburban clinics that provide primary and preventive care, and canceling purchases of experimental medical equipment.

The change, Ms. Gideon of the Forbes Health System said, reduced her hospital's operating costs to an estimated \$33 million this year from \$46 million last year.

Tougher Times Ahead

As the pace of change quickens, however, some economists say that more workers may be out of jobs, and for longer periods. Some may have to take lower paying jobs and others may need to move out of the region to find work. The jobless rate was 6.9 percent in July, the same as the national rate. And almost none of the hospitals are unionized, so workers have few contractual protections to ease the transition.

The biggest shake-up in Pittsburgh's health industry will occur if hospitals start dealing aggressively with the oversupply of beds. Pittsburgh has more than three times as many beds per capita as the nation, on average. On any one night in the metropolitan area nearly 30 percent of the 10,600 beds are vacant.

Such high hospital vacancy rates are a national problem, and pressure to eliminate the oversupply of beds would increase under a system that emphasized preventive treatment and steered more people to outpatient care.

A half-dozen hospitals have closed or merged in the last three years and, this year, hospitals have laid off 1,000 workers, from administrators to housekeepers.

A \$60,000 Job, Lost

Gloria Blint moved here with her husband and two small children from Erie, Pa., last summer to take a \$60,000-a-year job as director of communications at a local hospital. In April the hospital eliminated many administrative jobs, including Ms. Blint's.

"I've been out of college 13 years and I've never lost a job," she said. "This was a shock."

Ms. Blint has not been able to find a comparable job in the region and does not want to uproot her family by moving again. She is considering starting her own advertising agency. "I'm going to stay the heck out of health care," she said.

Since losing his job as a personnel director at an area hospital in February, Jim Anderson, 57, said he has sent out 900 résumés and had 17 interviews for jobs as far away as Wisconsin. "A lot of human resource people are out of work," he said. He finally got a job, starting this month, at a hospital in Rome, N.Y.

Even the region's prestigious aca-

demic medical center, the University of Pittsburgh Medical Center, is laying off workers and shifting them in large numbers. The center, a pioneer in transplant surgery and cancer research, is the region's largest private employer, with a staff of 12,000.

Cutback on Technology

In June, the center laid off 250 workers and eliminated another 250 empty positions, mostly in administrative areas. The center is also shifting about 400 employees from its hospitals to new suburban clinics that will provide primary care, said Jeffrey A. Romoff, the center's president.

The center, which has a \$1.3 billion annual operating budget, and the region could be hurt financially if an overhaul of health care limits peoples' choice of hospitals, Mr. Romoff said. Three-quarters of the center's patients come from outside Pittsburgh. "The Clinton plan recognizes this problem,

A renowned medical care industry will have to retool.

but how it will work out is uncertain," he said.

The prospect of change in health care is also putting a damper on purchases of new medical technology; Mercy Hospital, for example, has decided against spending \$3.1 million on an experimental scanning device used for studying the brain and other organs.

"We are reviewing all new requests for technology, to make sure we can manage them within our cost structure and remain competitive," said Michele Rone Cooper, a vice president of Mercy Health System, which operates the non-profit teaching hospital.

Such caution is hurting Pittsburgh's nascent medical technology industry, which includes about 75 companies and 5,000 employees.

"Quite frankly, I don't see any new medical device companies starting up, and there is going to be a tremendous struggle for the others, without mergers or something like that," said Irene R. Skolnick, president of Dymax Corporation, a manufacturer of medical probes and scanning devices. She said declining sales had forced her to lay off three of the company's 25 employees, put two others on part-time schedules and reduce health benefits and salaries for everyone else.

But Ms. Skolnick is optimistic about her company's prospects under a changed health system. "In the long run," she said, "it will play into our hands because we're improving the effectiveness of medicine and reducing its cost."

NY Times

10/3/93

Mr. Huber, you can begin.

STATEMENT OF GEORGE A. HUBER, VICE PRESIDENT AND COUNSEL, UNIVERSITY OF PITTSBURGH MEDICAL CENTER

Mr. HUBER. Thank you, Congressman Coyne and thanks to the members of the subcommittee for this opportunity to testify. In addition to my role at the University of Pittsburgh Medical Center which we consider to be an academic medical center and not just a teaching hospital, I also have responsibility for the human resources function which, as indicated, includes 12,000 employees. Not only their employment but also their benefits.

In that respect we are somewhat on the horns of a dilemma. On the one hand we are very much concerned about health care, health insurance for our employees, and many of the concerns that have been expressed here today and the potential costs of providing those kinds of benefits to our employees.

On the other hand, we are concerned about, as are other health care providers, the substance of what we do, so it could very well be that what we get for what we do will be less, but what we provide for our employees will be more, and certainly that is something that we must cope with and face.

Fortunately, though, we must commend the administration in its proposal for an act to substantiate health care reform, the recognition of the academic medical center and its unique role in the delivery of health care services in the United States, that being the provision of primary and complex patient care, medical and health care education, and biomedical and biotechnology research.

The University of Pittsburgh Medical Center is obviously located in Pittsburgh, Pennsylvania, a locality of our country that has seen extreme changes in the economy. The renaissance periods of Pittsburgh are well known, but they have included the decline of heavy industry and massive dislocation of the work force, followed by the emergence of service industries and stabilization of employment in recent years. Perhaps more so than any other factor the growth of health care enterprise in Pittsburgh has significantly anchored what had been a vulnerable regional economy, yet for the reasons I have mentioned previously the rescuer may now be at increased risk.

Therefore we recommend very careful consideration about what health care reform will entail for us not only as an employer but also as a significant provider of health care services. The impact of health care in Pittsburgh can be seen in the statistics pertaining to the 14th Congressional District represented by Congressman Coyne, which is roughly the city of Pittsburgh with a population of nearly 600,000 people.

Health care provides jobs for more than 108,000 individuals in 22 institutions, exclusive of nursing homes. Even more specifically the UPMC or the University of Pittsburgh Medical Center exemplifies the regional economic vitality that is characteristic of the 130 academic medical centers across the country. With more than 12,000 employees, the medical center provides inpatient care in its 1,400 beds, trains students in 6 schools of the health sciences, and makes available state-of-the-art facilities for the research efforts of many of the 2,000 faculty.

Through shared faculty, the medical center also works closely with two Veterans Administration Medical Centers nearby. The medical center budget is approximately \$1.3 billion, and more than \$214 million in local, State, and private sector support has been awarded to university faculty for their peer reviewed research with substantial emphasis on the biomedical and biotechnical areas.

The medical center is making approximately \$14 million in payments in lieu of taxes over a ten-year period to both the city, the city school board, and to the county. Uncompensated care in all categories is provided by the medical center in the amount of \$112 million. An additional \$600 million of economic activity is indirectly generated in the regional economy as a result of the University of Pittsburgh Medical Center through patients coming from other areas, students, visitors, families, and friends. We do have concerns, though.

We have concerns about the adequacy of the pools identified for graduate medical education and indirect medical education in light of proposed reductions in the Medicare funding mechanisms, particularly the \$214 billion savings to be found in Medicare, the elimination of the disproportionate share payment, reductions in Medicaid of \$65 billion, and a reduction of the IME rate to 3 percent from the current 7 percent. Why is that important?

Nationally, academic medical centers service 30 percent or represent—or Medicare represents 30 percent of the reimbursement to these centers. Locally in Pittsburgh because we have an older population, 47 percent of the revenue to our hospitals is the result of service to the Medicare patient. Thirteen percent results from service to the medical assistance patient.

What does this mean to the University of Pittsburgh Medical Center? A reduction of 1 percent in Medicare reimbursement will result in the termination of 70 employees. A 1 percent reduction in medical assistance reimbursement to the University of Pittsburgh Medical Center will realize a reduction of 30 employees at the University of Pittsburgh Medical Center.

What are we doing to combat this? We are not sitting back and doing nothing. We have invoked cost containment measures. This past year we have eliminated 500 positions. Our rate of increase in the budget for this year is zero, and that has been ratcheted down over the past 3 years from 10 percent to 3 percent to zero. There is, however, quite frankly uncertainty as to the impact we may anticipate of health care reform in our hospitals.

Have we prepared well enough to meet these current and future challenges? Our employees, just as your employees, want to know whether their jobs will be affected, whether or not we will be able to afford the benefits we have afforded to them in the past and what does this expense mean as far as patient care is concerned?

We believe, and we think this is important, that we play a very important and vital role from an economic standpoint and from a work force standpoint. We can serve as the anchors within our regions for the alliances and networks with other organizations, through electronic and human resource connections to outlying areas. We must expand our clinical and training capacities in primary care to make basic health care reasonably priced.

We are willing and the best prepared to perform biomedical research to improve patient care and health outcomes research to evaluate clinical practice. We are already working on new guidelines to provide guidance on clinical standards. We are providing and will continue to provide the guidance, stimulus, and expertise to educate American citizens from the beginning of elementary school through the end of their formal education on health promotion, and the health system to ensure better understanding of the system and how to use it efficiently.

Overall academic medical centers with our unique characteristics and strengths should be the framework for national health care reform. I have also submitted with my testimony a paper that we have prepared entitled Academic Medical Centers and Reform: The Cornerstone of a New American Health Care System, which elaborates on these points. We will continue to nurture our scientists for after all, thanks to them and our physicians I believe we Americans enjoy the finest health care system in the world.

Again, thank you very much for this opportunity to testify. We, too, support health care reform and the deliberations that it has created. We believe that the process should be a deliberate and a careful one, and we hope that we will continue to be consulted and play a role in how it is ultimately formulated and enacted.

[The prepared statement and attachment follow:]

**STATEMENT OF GEORGE A. HUBER, ESQ.
VICE PRESIDENT AND COUNSEL
UNIVERSITY OF PITTSBURGH MEDICAL CENTER**

Good morning, Chairman Stark, and Members of the Subcommittee on Health of the House Committee on Ways and Means. My name is George A. Huber, and I am the Vice President and Counsel of the University of Pittsburgh Medical Center. I greatly appreciate this opportunity to provide testimony to the Subcommittee on the projected impact of President Clinton's health care reform plan on our institution, the local and regional economy, and our workforce.

I wish to specifically thank Congressman Bill Coyne, who for many years has so ably represented the 14th Congressional District in Pittsburgh, for making this appearance possible. He has been a staunch supporter of the University of Pittsburgh, the University of Pittsburgh Medical Center, and Pittsburgh's other health care institutions over the years.

Although we have not yet had the opportunity at this time to review completely the President's legislative proposal for health reform, we would like to commend the Administration for its recognition of the unique, three-fold roles of academic medical centers, such as the University of Pittsburgh: first, primary and complex patient care; second, medical and health education and training; and third, biomedical and biotechnology research. A number of provisions in the bill wisely provide for a continuation of government funding for graduate medical education, encourage patient referrals from health plans to academic centers, and support the specialized functions of the academic centers with designated funding.

Health care obviously is not an abstract or theoretical concept. It is care for sick people to make them well and keep them healthy, by trained professionals, in the person's home or a health care facility, such as an office, a clinic, a hospital, a nursing home, or some other location for providing the care. The numbers of individuals employed, the number of inpatients and outpatients, and the number of beds are significant, because they represent various encounters individuals have with the providers and facilities in their health care delivery system.

In Pennsylvania, for example, according to 1991 data from the Hospital Association of Pennsylvania and the American Hospital Association, Pennsylvania hospitals and doctors provided care for 1.9 million admissions, including 738,000 Medicare discharges, nearly 250,000 Medicaid discharges, and overall 23.7 million outpatient visits. Two hundred eighty seven thousand individuals are employed in health care in Pennsylvania, according to the 1991 data. Approximately 92 percent of Pennsylvania residents have health insurance.

The Renaissance periods of Pittsburgh are well known, but they have included the decline of heavy industry and massive dislocation of the workforce, followed by the emergence of service industries, and stabilization of employment in recent years. Perhaps moreso than any other factor, the growth of the health care enterprise in Pittsburgh has significantly anchored what had been a vulnerable regional economy. Yet, the rescuer may now be at increased risk.

The impact of health care in Pittsburgh can be seen in the statistics pertaining to the 14th Congressional District represented by Congressman Coyne, which is roughly the city of Pittsburgh with a population base of nearly 600,000. Health care provides jobs for more than 38,000 individuals in 22 institutions exclusive of nursing homes. More than 7,500 hospital beds are available with an average occupancy rate of 73 percent. Total admissions for 1991 amount to 215,000, with one third of these admissions (76,000) involving Medicare patients. Thirty-thousand discharges involved Medicaid patients. Two and a half million outpatient visits were recorded. Total annual expenses for Pittsburgh hospitals for FY 1993 amounted to \$2.1 billion.

These data represent a significant increase in the statistics over the ten year period between 1981 and 1991 and clearly reflect the economic and industrial transformation Pittsburgh has undergone in the last 10-15 years.

Even more specifically, the University of Pittsburgh Medical Center exemplifies the regional economic vitality that is characteristic of the 130 academic medical centers across the country. With more than 10,000 employees, the Medical Center provides inpatient care in its 1,400 beds, trains students in six Schools of the Health Sciences including Medicine, Nursing, Pharmacy, Dental Medicine, Graduate School of Public Health, and Rehabilitation Science, and makes available state of the art facilities for the research efforts of many of the 2,000 faculty. Through shared faculty, the Medical Center also works closely with two VA Medical Centers nearby. The Medical Center budget is approximately \$1.3 billion. More than \$214 million in local, state, and federal government and private sector support has been awarded to University faculty for their peer-reviewed research, with substantial emphasis on the biomedical and biotechnology areas. Consistent with increasing pressure from local taxing authorities on not-

for-profit entities, the Medical Center is making approximately \$14 million in payments in lieu of taxes over a ten year period. Uncompensated care, in all categories, is provided by the Medical Center in the amount of \$112 million.

An additional \$600 million of economic activity is indirectly generated in the regional economy as a result of the University of Pittsburgh Medical Center through drawing patients from outside the area, attracting out-of-area students in its educational programs, inviting visitors for seminars and conferences, and welcoming family and friends of patients and students.

The School of Medicine at the University of Pittsburgh with a current enrollment of 551 graduated 125 students last May. For the academic year 1991-1992, there were 790 residents in graduate medical programs. Approximately thirty percent were training in the specialties considered primary care, with an additional 92 residents in related subspecialties of internal medicine.

To address national concerns about the need for more physician generalists, the School of Medicine developed a new curriculum for its students that provides the increased patient care which motivated many to join the profession in the first place. The curriculum, now in its second year, provides patient contact and direct clinical experience to first year medical students almost from the first day of their academic experience. Second year students, with a year of increased patient contact behind them, have found their experiences rewarding and hopefully compelling enough to urge them in the direction of primary care.

Health care is important to the citizens of Pittsburgh for their health and wellbeing, the quality of their lives, and the growth and stability of their economy.

But what connection do these data have with the President's proposal and with the reform legislation that will eventually be passed by Congress? An exact answer is difficult to formulate since the specific details of the plan that will pass Congress are unknown. I wish to offer a few thoughts, however, about the possible effect certain provisions of the Clinton plan may have.

Academic medical centers are unique institutions with their own missions. They provide the same primary services as do community and rural hospitals, but they also care for the sickest patients with the most complex conditions; they train the professionals while they are treating patients; and they provide the important bridge at the bedside between the laboratory and clinical care following research. It is important to note that not every teaching hospital functions as an academic medical center and should not be classified as one for funding purposes since they have different missions. At every level of the hospital continuum, hospitals of varying types serve their respective patient bases. At academic centers, an appropriate supply of primary care patients is needed for treatment, research, and training purposes. Recognition of these differences must be maintained to preserve the quality of the medical education system and biomedical research in this country.

Primary care is not the exclusive bailiwick of the generalist physician. The specialist in cardiovascular disease or gastroenterology, for example, can provide basic health services to patients as well, with relatively little retraining or modification of their practices. Obstetricians and gynecologists, now included as primary care providers, will be treating reproductive conditions in the context of the health of the individual as a whole being.

The President has proposed that two pools be established relative to academic medical centers: one for direct graduate medical education funding (GME) and the other for the indirect costs of graduate medical education (IME). By the year 2000, \$5.8 billion would be available in the GME pool and \$3.6 billion in the IME pool. We have concerns about the adequacy of these pools, in light of proposed reductions in the Medicare funding mechanisms, particularly the \$124 million "savings" to be found in Medicare, the elimination of the disproportionate share payment, reductions in Medicaid of \$65 billion, and a reduction in the IME rate to 3 percent from the current 7.0 percent. Medicare reimbursement, on average, represents 30 percent of the business of teaching hospitals, so major changes in this reimbursement factor can greatly impact hospitals. In Western Pennsylvania, where the population is much older than the national average, Medicare patients comprise 47 percent of the patient base at regional hospitals. It appears that even the surcharge of 1.5 percent of the total premium amount on all plans may not adequately fund these educational pools. The combination of Medicare and Medicaid payors involves approximately 60 percent of hospital admissions in Western Pennsylvania.

Academic medical centers, in general, have initiated cost containment measures in recent years in particular to constrain rampant growth, position themselves more realistically in light of flatter margins, and try to anticipate the impact health reform may have on their organizations. At the University of Pittsburgh Medical Center, three years of voluntary and mandated controls have reduced annual budget growth from 10 percent to three percent to less than one percent. This has not been accomplished without significant staff and programmatic costs. For

instance, the Medical Center workforce was recently reduced by four percent, including the layoffs of 250 employees and failure to fill another 250 vacant positions. Other Pittsburgh hospitals have reduced their workforces at similar levels. There is, Mr. Chairman, quite frankly, uncertainty as to the impact we may anticipate of health care reform on our hospitals. Have we prepared well enough to meet these current and future challenges? Our employees want to know whether their jobs will be affected.

Several indicators are encouraging as a result of the strategic planning and belt-tightening performed by our hospitals in Western Pennsylvania. Experiencing a change in total hospital expenses in FY 1980-1981 as high as 17.4 percent, they have ratcheted down the rate of growth to 5.8 percent in FY 1992-1993 and 3.4 percent in FY 1993-1994. The current rate is an eight year low with even greater limitations on growth being seen for the current fiscal year. Operating margins over the last ten years have declined to 1.12 percent for FY 1993 from a high of 6.5 percent in FY 1985. The current rate is the lowest average percentage ever documented in this region. Thirty-seven percent of our regional hospitals showed a net operating loss for FY 1993, although hospitals in the City of Pittsburgh reported a gain of 1.68 percent. Rural hospitals in Western Pennsylvania, on the other hand, reported a 0.12 percent operating margin.

Proper consideration of economic and workforce interests in health care reform must be focused at academic medical centers. We can serve as the anchors within our regions for the alliances and networks with other organizations through electronic and human resource connections to outlying areas. We must expand our clinical and training capacities in primary care to keep basic health care reasonably priced. We are willing and the best prepared to perform biomedical research to improve patient care and health outcomes research to evaluate clinical practice. We are already working on new guidelines to provide guidance on clinical standards. We are providing and will continue to do so the guidance, stimulus, and expertise to educate American citizens from the beginning of elementary school through the end of their formal education on health promotion, disease prevention, and the health system to ensure a better understanding of the system and how to use it efficiently. Overall, academic medical centers with our unique characteristics and strengths should be the framework for national health care reform. I am also submitting for the record a brief position paper entitled "Academic Medical Centers and Reform: The Cornerstone of a New American Health Care System" which elaborates on these points.

Whither will we go in the next few years to come? Academic medical centers, such as the University of Pittsburgh, look to the President for his assurance that its patients and its students can be mutually accommodated. We will continue to nurture our scientists, for after all, thanks to them and our physicians, Americans now enjoy the finest care in the world. We will look to new strategies and devices to enable us to provide care at an appropriate cost and in an efficient and effective manner. We pledge our commitment to working with you and your Congressional colleagues as the reform process develops. Thank you.

Attachment



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ACADEMIC MEDICAL CENTERS AND REFORM:

THE CORNERSTONE OF A NEW AMERICAN HEALTH CARE SYSTEM¹

I. Introduction

Within the entire health care system, the United States is fortunate to have developed more than 125 academic medical centers, many of which are the envy of the international medical community. Few, if any, of the previously developed reform proposals address the role of academic medical centers in American medicine and their unique responsibility for health care, research, and education. Neglecting to include a significant and distinct role for the academic medical center within any national health care proposal, in our opinion, could lead to a disastrous (and potentially embarrassing) deficit within American health care. Therefore, we have addressed our observations and recommendations to the general role of "academic medical centers." This paper first provides some background observations concerning the history and role of academic medical centers within the health care community, followed by a series of recommendations. The recommendations are divided into those that address the concept of health reform generally and those that are specific to the future role of academic medical centers within the system.

II. Observations

A. Creation and Mission of the Academic Medical Center

1. Congress and the Executive Branch have jointly supported the development and growth of academic medical centers over the years through the sponsorship of research, reimbursement for patient care in government insurance programs, the encouragement of disease-specific initiatives, and the subsidization of health professional education. Academic medical centers have the unique missions of integrating primary and complex patient care, educating physicians and other health care professionals, and performing research. They are the research and development arms of the health care industry, and they are essential to its future vitality and productivity. No industry or enterprise can long survive without investment in research and development.

a. Since the passage of the Social Security Act almost 60 years ago², the United States government has subsidized the health and welfare of American citizens through coverage of senior citizens, dependents, disabled individuals of any age, and the poor.

b. Through Medicare and Medicaid, administered by the Health Care Financing Administration (HCFA), academic medical centers have become, to a very large extent, the front door of primary care for the vast majority of citizens whose health insurance is provided by the government.

2. Medical centers have willingly assumed this important responsibility because of their charitable nature as teaching and research institutions and because of the expectation of fair reimbursement from the

¹George A. Huber, Esquire, Vice President and Counsel, University of Pittsburgh Medical Center (UPMC); Eugenia Chambers Stoner, Esquire, Director, Federal Government Relations, UPMC; Lazar M. Palmick, Esquire, Assistant Counsel, UPMC; Thomas Detre, M.D., Senior Vice Chancellor for Health Sciences, University of Pittsburgh; and Members of the Executive Staff of the UPMC. The UPMC, a 1,600-bed academic medical center, provides primary and advanced specialty care to patients, performs biomedical and biotechnological research, and educates and trains health care professionals. The Medical Center employs 12,000 people and has an estimated annual economic impact of \$2 billion. The UPMC, along with its faculty and staff, has been internationally recognized for excellence in organ transplantation, psychiatry, neurosurgery, genetics, cancer treatment, and other areas.

²August 14, 1935, Pub.L. No. 74-271, 49 Stat. 620 (codified as amended at 42 U.S.C. Sections 301 et seq.)

government. As a result, Medicare beneficiaries and Medicaid recipients spanning all ages receive their treatment from academic medical centers.

3. The nation's academic medical centers, most of which are affiliated with public and veterans' hospitals, also care for the medically indigent (the urban poor, under-insured, and uninsured), extremely ill patients with complex and unusual problems, and patients referred from rural or small community hospitals without any government coverage.

4. Other federal legislation furthered the development and implementation of the national academic biomedical and biotechnical infrastructure. The research and treatment enterprise developed at the National Institutes of Health (NIH)³ is the training ground for the nation's best scientific and medical talent, who spend parts or all of their careers at NIH, completely subsidized by intramural research funding from the government. For those who leave government service, academic medical centers provide an appropriate forum for the continuation of their critical work. More importantly, extramural funding from NIH flowing directly to academic medical centers and researchers provides the backbone of biomedical research. Academic medical centers have the human resources, including faculty and patients, laboratory facilities, and commitment to expand scientific knowledge, thereby improving patient care presently, and, just as importantly, in the future.

5. Through other administrative agencies within the Public Health Service⁴, the government, with support from Congressional appropriations, sets the nation's public health policy agenda and funds implementation at academic medical centers.

6. In the educational area, the government funds medical and other health profession students through financial aid programs, including loans and the sponsorship of training, research, and clinical care at academic medical centers.

7. Federal legislation and regulations have channeled resources provided by federal enactments into academic medical centers. Support from the free-market economy has been synergistic with government initiatives to further develop and support the medical centers. Taking these various government programs and funding sources together, the country has created a national network of academic medical centers, unlike those of other countries. The United States is one of the few countries where substantial medical progress and breakthroughs occur. We take for granted as a national "prerogative" that academic medical centers are the places where the life-saving and life-enriching results of research in AIDS, cancer, mental disorders, orthopaedics, geriatrics, cardiology, pediatrics, transplant, and other areas take place. Their operation and unique missions are cornerstones upon which the new national health care system must continue to rest.

B. The Role of Academic Medical Centers in the Nation's Economy

1. The American health care enterprise has been the only sector of the U.S. economy immune to recession and one of few areas with any significant new employment.⁵ Health care provides jobs to the American people and is the economic engine for many local, state, and regional economies. The national economy has also been bolstered by the growth of health care. American hospitals employ an estimated five million people⁶ and academic medical centers employ nearly one million people.⁷ Often a region's largest employer, the academic medical centers, with their hospital(s), medical school, and university affiliates, have been the mainstay in otherwise dying economies.

³Public Health Service Act, July 1, 1944, Pub.L.No. 78-410, 58 Stat. 682.

⁴Such as the Centers for Disease Control and Prevention, the Agency for Health Care Policy and Research, the Food and Drug Administration, the National Institute for Occupational Safety and Health, and the Health Resources and Services Administration.

⁵ The Health Care industry has had a recent 10% growth rate in employment. U.S. Department of Labor, Bureau of Labor Statistics, Employment and Earnings. Washington: U.S. Government Printing Office. Monthly reports for January 1985--December 1991.

⁶ American Hospital Association, AHA Hospital Statistics 1992-1993, based on 1991 data.

⁷Association of Academic Health Centers, 1400 Sixteenth Street, N.W., Washington, D.C. 20036.

2. Health care research also preserves a role of world leadership for the country. Even though recent Federal underfunding has begun to erode the fragile research ecology, threatening our international dominance, the American health care industry remains first in the world. Research at academic medical centers is an indispensable element of world commerce and one of the strongest components of America's reputation and strength. The academic health establishment, including its research component, has contributed to a favorable balance of trade and the tradition of American pre-eminence in the development of new pharmaceuticals, medical devices, and related technology. Few sectors of the American economy can match the sustained vigor that still exists in the health and biomedical areas, an expertise that is valued--and paid for--by other countries of the world.

C. Summary

Academic medical centers were created by the government's involvement in the health care process. They have grown and expanded because of the government's active participation in providing funding and incentives for them to offer the services that government wanted the academic sector to assume. The missions of the centers--education, patient care, and research--not only fit this model, but foster major economic growth that drives our local and national economies.

III. Recommendations

The current health care system of private and public sector collaboration, with academic medical centers as the focal point, can be revised to bring about expanded access, cost containment, greater efficiency and efficacy, administrative simplification, and reasonable evaluation and regulation of health resources. With this understanding in mind, we wish to offer suggestions on the general reform of the American health care system, as well as specific recommendations regarding the roles that academic medical centers should play within that framework.

A. General Recommendations

1. The citizens of America, regardless of income or employment, deserve basic health care with reasonable access to appropriate health providers. This access should be encouraged by having employers required to purchase coverage for a basic health care plan from a variety of potential insurers with some co-payments according to income and at a minimum level so that citizens would have an economic interest in their health.

2. A National Health Board, composed of health care experts, distinguished laymen, ethicists, and consumers, should define a basic benefit package that would also permit the expansion of benefits once targets for cost savings have been reached. The Board should require insurers to community rate their products and prohibit pre-existing condition clauses.

3. Mandatory, realistic, and comprehensive federal practice guidelines must be the basis for health care and reimbursement under the new system. See Specific Recommendation 6 *infra*.

4. Effectiveness, efficiency, and fiscal responsibility should be strongly encouraged through data-based practice, cooperative purchasing, and administrative simplification. See Specific Recommendation 7 *infra*.

5. Revenues should come from several sources: individual and corporate taxes on health benefits exceeding the cost of the basic package; a phase-in of an increased retirement age from 65 to 67; Medicare withholding from all personal earned income; and other kinds of taxes. Reduction of the cost of the regulatory burden on health care providers must be looked at as a possible revenue source or savings.

6. Some provision must be made for the sophisticated medical needs of certain patients that should only be addressed for the sake of efficiency at academic medical centers, which have the unique resources and accept the responsibility.

a. Academic medical faculty along with health outcomes researchers under the auspices of the Agency for Health Care Policy and Research should be used to form panels to design practice guidelines. The panels should also initiate large-scale trials based on the frequency and cost of medical procedures. New technology would be eligible for reimbursement only if patients agree to participate in clinical trials or scientific registries so as to track health expenditures and outcomes.

b. Reimbursement by all third party payers should be based on the guidelines until the results of clinical trials validate or modify practice modalities.

c. Tort reform should be linked to mandatory, realistic, and comprehensive federal practice guidelines, with health care professionals being held harmless when there is adherence to the guidelines.

7. The efficiency of health care must be improved.

a. The federal government should insist on data-based practice for efficiency. Analysts should look at the care packages from across the country and integrate guidelines as medically appropriate as a model for efficiency, effectiveness, and fiscal responsibility.

b. Administrative simplification measures should be put into effect as a high priority, particularly a uniform claims form and electronic billing, to avoid redundancies and consumer confusion. Computer technologies developed for specific health care clients should be made available to other providers, rather than developing "new" applications each time. Standardization of health care computer software would achieve significant savings and reduce staggering inefficiencies. Multiple audits should be prohibited as unnecessary and duplicative.

c. An on-line, "smart-disk," containing a patient's entire medical record including all laboratory and diagnostic findings, should be developed by private industry, academic medical centers, and the Library of Medicine with protection of confidentiality and the ability to be accessed remotely.

8. Where health care savings have been realized by other elements of the plans, employers should be obligated to retrain and reassign the laid-off employees. The training should be conducted at the regional academic medical centers that have established training programs to receive these new students, i.e., schools of public health, schools of health related professions, biomedical engineering, and the like. Health care costs cannot be sharply reduced without a loss of jobs unless retraining of individuals and increased research and development take place, which could expand employment opportunities.

9. Academic medical centers should provide the guidance, stimulus, and expertise to educate American citizens from the beginning of elementary school through the end of their formal education on health promotion, disease prevention, and the health system to ensure a better understanding of the system and how to use it efficiently.

10. A dependable funding mechanism for medical education should be developed such as a national medical education pool, which would be funded by mandatory contributions from health care insurers based on market share and profit.

11. A requirement for scientists and their institutions receiving research funding should be the validation of the subject of the research by longitudinal studies of the design, cost-effectiveness, operation, and implementation of the research. The nature, cost, and scope of the diffusion of new technology would then be a decision of the National Board, based on the studies. Preclinical research and mechanisms for its continued support must also be included in the proposal, to nurture the academic and clinical work that gives rise to full-blown research.

12. To ensure that promising treatment and technology research can be tested and improved for eventual clinical care, the anchor academic medical centers should be guaranteed reimbursement for the physician and hospital service delivery costs related to promising treatment and technology, formerly denominated as "experimental."

13. A task force appointed jointly by the Secretaries of Health and Human Services and the Department of Veterans' Affairs should examine the feasibility of completely merging VA hospitals and facilities with the anchor academic medical centers.

IV. Conclusion

Academic medical centers with their unique characteristics and strengths should be the framework for national health care reform. By establishing regional health care networks, anchored, managed, and operated by academic medical centers under the auspices of a National Health Board, the administration would achieve meaningful and effective health care reform.

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Mr. COYNE. Thank you all for your testimony. I would like to address this question to Mr. Huber and Mr. Brennan.

Each of you run businesses that would be large enough to set up its own corporate alliance under the Clinton plan. Would you set up your own individual alliance and what factors would you consider in making a decision as to whether you would or would not?

Mr. BRENNAN. First of all, we would certainly prefer to have a corporate alliance because we believe we could manage it very well. However, the way they are structured we would end up paying 95 percent of the employees' health premium. The problem we have is that we would be charged the 1 percent tax, and States could step in and pull us out of a corporate alliance, and into the regional alliance on a single-payer State plan. We would lose ERISA benefits. In total we would pay 95 percent of employees' base pay in health care costs, so there really is no incentive. In fact, there is no possibility for a company like ours to utilize a corporate alliance.

Mr. COYNE. Mr. Huber.

Mr. HUBER. I would answer the question by saying that we would prefer to set up our own alliance for two reasons. First of all, we think that we can provide the best services to our employees. We have that much confidence in what we do, and second, we hope to be a major player as a provider in other alliances, and we believe that if we believe in ourselves and that we are cost conscious and do what we are supposed to do, that our opportunities within other alliances and as serving as providers for other alliances will strengthen our position.

Mr. COYNE. Would either of you or both of you object to putting your insurance purchasing in the hands of the regional alliances?

Mr. BRENNAN. Well, as I stated earlier, we believe that our experience clearly indicates that we can manage it better. We can provide more incentives to our employees to work with us, again, in obtaining better benefits and yet lowering the costs. So our preference clearly is to manage it ourselves, and we have a history that supports that preference.

Mr. HUBER. That is a very difficult question. Yes. I don't know that I feel comfortable enough to be able to answer that question. I am not sure I fully understand exactly what the regional alliances will be doing from an insurance standpoint, how that will be structured or what the relationship will be between a regional alliance and possibly other health care providers that will structure themselves as insurance companies.

I have some reservation about structuring ourselves as an insurance company. I don't know that we have the experience or know enough about that part of the industry to do so. On the other hand, I don't feel comfortable to say that I have enough confidence in what the alliances will be doing to say that I would put full confidence in them. I think there has to be a lot more learning in the total process to make any kind of a commitment along those lines from our perspective.

Mr. COYNE. Thank you. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman. And I am sorry I missed out on some of the testimony, but I am pleased to have this panel before us.

And I would like you to comment, if you would, on the conversation that I had with Mr. Tyson, which I know some of you heard, because the economic impact concern that I have is that if you turn health care costs into a fixed cost, you will, in a sense, disconnect most of America's minds from the issue of cost control, and I think you all demonstrate those relationships through which medical centers and the private sector have developed really progressive and powerful people-oriented approaches to cost control.

And I would like your comment on that, and I have one other aspect of that question that I would like to get to, if possible.

Mr. BRENNAN. I think my first comment would be that I think you were right on in your discussion of cost alliances. They are really not viable in today's version of the administration plan. The economics flat out just don't work. So I think you drove that point home.

The second point I thought this morning was accurate from the standpoint that we have included cost-savings incentives in our employee plan as well as wellness programs, we have had great participation, and we are signing up more people that want to be with us. Our employees can opt into an HMO if they choose to do so. We have built in flexibility. There is no question that people working together will make a system work.

When a system is simply mandated and there is no incentive on the part of employees to make things better for the company and for themselves, then I don't think the plan will work. So my response is that I believe that corporate alliances are very important. Ours I think has proven to be successful because we have sensitivity to our employees, and we have participation on the part of our employees.

So my response is that it is very important for us to continue our own program, but the economics of the administration plan would not allow us to do so.

Mr. JASINOWSKI. Let me come at it from the regional alliance side and make an argument which is complementary to what has just been made. Manufacturers provide the best health care in America today and we do a better job of controlling cost than any other part of the system. And, in fact, our rate of cost increase is declining.

It is still much too expensive and that is why we want health care reform, but in fact we are doing a better and better job all the time.

Mrs. JOHNSON. And I know you are doing a better job than the public sector.

Mr. JASINOWSKI. That is probably right too.

Mrs. JOHNSON. Your costs are rising at a considerably lower rate.

Mr. JASINOWSKI. I am sure that is correct. My members large and small feel in general that we want to stay in the frontlines of improving quality if we are to have an employer-based system. Manufacturers are responsible. They would like to know what they are responsible for.

And we have been critical of the 5,000 employee level because we think that will take most manufacturers out of the frontline of controlling costs and improving quality and the fact is we don't think you can simply turn it over to an alliance and be satisfied, since

there is a community marriage between benefits and wages that are part of the way a company runs.

So if we are going to provide benefits to our employees, we want to provide the right kind of benefits at a reasonable and affordable cost and with good quality.

So our judgment is that to continue making that progress in controlling costs, we need to dramatically scale back the regional alliances to something in the neighborhood of 100 to 500 employees, which by the way at the 500 employee level, is the definition of small business under the Federal Government, and the regional purchasing alliances were originally thought of as a way to pool small companies so that they could compete better and we support that idea.

So we support the purchasing alliances at a certain level because it allows small firms to pool their buying power, but not at the level that they have been proposed.

Mr. HUBER. I might comment upon your comment from the provider perspective. I think it is an excellent point. If you have global budgets, if you are increasing coverage to 37 million more people, if you have the authority to change premiums, if you are reimbursing at current Medicaid levels or actually below current Medicaid levels by 5 percent at the 95 percent level, are you creating nothing more than a fee-for-service system that may not adequately pay the costs to service the patient and what incentives there are in the system for the provider to realize economies if they are already starting off in the hole?

Mrs. JOHNSON. I think that is a very important point. And I would note at least it appears to me that the administration is relying primarily on giving individuals the choice of plan by putting everybody in the alliance and everybody having a choice of fee-for-service versus managed care versus HMO plan.

But they have testified that the variation in cost would be minimal. It appears to me that the majority of employers, and I don't know, Mr. Jasinowski, whether you have any data on this, but it appears that the majority of employers are now offering their employees those kinds of options.

Mr. JASINOWSKI. Certainly manufacturers are.

Mrs. JOHNSON. Then we have in the system the individual choice that the administration is going to rely on, plus we have the employer energy and concern to control this health care cost, so we have far more force for control in the current system.

I was pleased that you showed examples using some limit on tax deductibility to force cost control as opposed to a global budget which through the premium will fix cost limits and because of the way the bill is structured, will force those cost limits down very precipitously and with clear impact on availability and quality.

Limiting tax deductibility to something like the average cost plan will force the market to compete in the very range where the most cost-effective care can be provided. I think that would far more forcefully achieve the savings that the administration talks about, that is preferencing lower cost physicians and hospitals and other providers, than the more arbitrary mechanism of global budgets and premium caps.

As this debate goes forward, I hope all of you will look at that difference between tax deductibility as a mechanism which would be completely in the jurisdiction of this committee versus global budgets and premium negotiations, because I think in terms of preserving quality as well as reducing cost, that kind of mechanism with private sector involvement is more powerful than the other mechanism that shifts the responsibility to the public sector.

Mr. JASINOWSKI. If I may comment on that question, it is really a central question and, as you know, politically one of the most controversial there is.

Within our own board there is a division of opinion about whether or not we ought to do that or not. But most experts who looked at it said, look, if you want to have better employee and consumer cost consciousness, you better look at the tax system. As you know, Mr. Cooper has looked at the employer deductibility. We suggest in our testimony that really you need to look at the employee part too. All of that is very controversial.

But as you get into this financing area, we are all going to have to step up to the plate and say how are we going to finance any of this? And certainly that is a more effective way to do it if you want to have consumers control their buying decisions better.

Mrs. JOHNSON. As one of the Members who helped negotiate the new Cooper bill, that is Cooper/Grandy, I am very interested in that approach. I don't agree with Cooper tying it to the lowest cost plan because then I know, Mr. Huber, you are well aware of what happens with the lowest cost plan. They can be the lowest cost because they are lousy.

I am interested in flexing up Cooper in that regard. I am also interested in making the HPPC which governs employees under 100, which is 40 percent of employers, perhaps voluntary if we can deal with the risk issues in that context. But I think the debate out there between the Michel bill and the Cooper/Grandy bill is a very rich debate. It has analogous bills out there by Senators Lott and Chafee and Breaux in the Senate.

But I think that range of options could accomplish all the goals the administration is interested in accomplishing without running the risk of participating at a national level in some solutions with which we have had no experience.

Mr. JASINOWSKI. We certainly want to work with you in that regard.

Mrs. JOHNSON. I appreciate that.

Thank you, Mr. Chairman.

Mr. MCCRERY. Thank you, Mr. Chairman. I just have a couple of questions and we will get you guys out of here. You have been here a long time.

With respect to whether you would be better off under the Clinton plan, I am talking particularly to Mr. Brennan, your company, Mr. Jasinowski, the members of your association, or under your current system. You currently provide insurance for your full-time employees; is that right?

Mr. BRENNAN. We provide insurance for full-time employees and part-time employees who work over 30 hours.

Mr. MCCRERY. Can you tell me about what percent of payroll your costs are now for health care?

Mr. BRENNAN. Our cost as a percent of payroll are less than 7.9 percent.

Mr. MCCRERY. Oh, are they?

Mr. BRENNAN. Yes.

Mr. MCCRERY. So you would be better off—it seems like you would be better off staying as a corporate alliance, but you have said that there is no way you could afford to do that. Explain that a little bit more.

Mr. BRENNAN. What I am saying is in terms of managing it, in terms of working with the employees, in terms of finding better ways to operate, that would be preferable.

But the way the plan is written, you do not get the 7.9 cap in a corporate alliance, number one.

Mr. MCCRERY. But you have said that your costs now are less than that.

Mr. BRENNAN. But the difference between the regional alliance at 7.9 percent and the corporate alliance is that the corporate alliance is substantially higher and has no cap, so the difference from where we are today would mean going up from a 60 percent increase in the regional alliance to over 180 percent in the corporate alliance.

We really don't know today whether you can put part-timers in the regional alliance, and obtain a 7.9 percent cap, while keeping full-timers in the corporate alliance. The economics don't work.

We also don't understand the phase-in period. There is no question that we recognize that we are going to be economically impacted either way, and that is why I went back earlier and said a national plan should deal with those who do not have health coverage, who cannot afford it, or who are between jobs, or who have preexisting conditions, rather than change the entire health care system simply to benefit those who don't have health care coverage.

The issue is broader than where we fit on a percentage base, and that is the point I was making to the chairman.

Mr. MCCRERY. But if the Clinton plan were to pass, you would likely to join a regional alliance.

Mr. BRENNAN. If the Clinton plan passed, the answer is we would have no choice but to do that, but the impact on our company would be in the area of \$60 million on a company that earned \$100 million last year. And we are not that different from our competitors.

We are a low-margin industry and that is the reason we are so highly sensitized to this issue.

Mr. MCCRERY. What about you Mr. Jasinowski?

Mr. JASINOWSKI. I think I would speak for both large and small members. I will be happy to try to distinguish that for you. If you look at the resolution in my testimony, we identify a number of major benefits with the Clinton plan. And theoretically, manufacturing in general would benefit under the plan because we now pay high health care costs and theoretically cost shifting would be reduced.

And I think for that reason and others there is a substantial amount of support for parts of the Clinton plan. I think the concern and reservation that we have expressed is that the size of the proposed reform in terms of benefits, the adequacy of the financing,

and the bureaucratic structure and its impact on current competitiveness is such that because these are folks who make things and are very pragmatic, they say, we are not sure it is going to work the way it is supposed to work.

And as a result, we have taken a position of nonsupport on any plan. And there are considerable concerns with respect to the Clinton plan along the lines I indicated.

So that would be point number one. Second, if you are in a corporate alliance, many of the problems that were just identified would apply to large manufacturing firms, although since they have better profits and productivity, they wouldn't be as adversely affected, but if you look at the 1 percent surcharge and the State changes in all of that, many corporate alliances in manufacturing would have the same concerns that they have in retailing.

On the small business side, I think it is probably more favorable in manufacturing than it is in nonmanufacturing, small businesses in general. There are large incentives in the Clinton plan for small business and small manufacturing. And since we already pay high costs, I think probably more small manufacturers would benefit than would be hurt.

Mr. McCRERY. But the bottom line is, you would predict that if the Clinton plan were to pass, most if not all of your large manufacturers would end up in the regional alliances?

Mr. JASINOWSKI. You know, I think if they were not changed, a lot of them would move to the regional alliance option because it is easier for them to bail out rather than to deal with the way the corporate alliances have been structured, and that is one of the things that we are concerned about in terms of losing—as I said to Mrs. Johnson—the employer's commitment to cost control.

Mr. McCRERY. Thank you.

Mr. COYNE. Mr. Levin.

Mr. LEVIN. Thank you.

I am sorry that I missed your testimony. This has been kind of a cut-up day for everybody on the subcommittee and on the full committee, as we have come in and out. But let me assure you, there is very broad interest in these issues.

I just want to zero in on one issue and then you should go, I guess there is another panel, and we are likely to have more votes, et cetera.

In terms of the retail industry, we have had some discussions back home on this. One of the large retailers has its international headquarters in the district I am privileged to represent. The two of you sitting together, if I might say so, represent part of the problem. The retail industry says don't shift the cost unfairly to us. But manufacturing in this country says look, it has been shifted to us for decades. And in part, the shift has come from retailers. We are covering a lot of people in the retail industry through their spouses.

So members of the NAM are subsidizing members of the retail association.

Mr. JASINOWSKI. We would certainly second that analysis. I mean, not to pick on the retailers at all, but we have been subsidizing the retail industries.

Mr. LEVIN. I think you have. Earlier today there was a discussion about the early retirees and most of them are in industry,

which has been subsidizing the rest—much of the rest of the private sector, not only manufacturing, but for example, construction in a lot of States too.

So, the problem I see is in your testimony on behalf of the retail federation is I don't see the answer. If we are going to cover everybody and begin to cover people more fairly, then—and we are going to do it employer-based and not through a single-payer system—then the retailers are going to have to cover their employees.

Now, I mean, tell me logically what is the alternative?

Mr. BRENNAN. If I can, seeing as how you were not here, I would like to go back for a second. The point I made earlier is that the average retail employee produces \$1,750 in earnings per year. The average manufacturing employee contributes \$6,500 per year to earnings, so it takes 3.7 more retail employees to equal the productivity of one manufacturing employee. That is the way it is. That cost is taken into account in the cost of goods. That formula tells you how we run our business, and that is the way it has been for a long period of time.

Mr. LEVIN. So what conclusion do you draw sitting next to a distinguished representative of manufacturing?

Mr. BRENNAN. The conclusion that we draw is that we should find a method to cover those who are not insured, those between jobs, and those with preexisting conditions, and not attempt to revamp the entire health care system.

Mr. LEVIN. But forget the latter for a moment because that is a bit pejorative. Tell me, how do we cover the tens of thousands of people working 20, 25 hours in the retail industry who are not otherwise covered by their spouses, many of whom are in manufacturing?

We will get to that second point about the shift later.

Mr. BRENNAN. To your point, if I may, with regard to our part-time employees, over half are covered by other insurance plans. Coverage provided by spouses' plans is just a part of the 50 percent. For examples, we have a large number of employees who are schoolteachers who have other jobs and work part time to supplement their income.

I think it is important to make that point. If I can go on from there.

Mr. LEVIN. How about the 50 percent? We are talking about the 40 or 50 percent who have no insurance.

Mr. BRENNAN. Well, we have another 10 percent who are in between jobs.

Mr. LEVIN. So that reduces it.

Mr. BRENNAN. You still have a portion, 35 to 40 percent.

Mr. LEVIN. What do we do?

Mr. BRENNAN. I think that we look at ways to subsidize support for that group of employees so that we don't impose the same plan uniformly all the way across all industries at a level that we cannot afford to pay.

The issue that I raised earlier, if I may finish, is jobs. I am not sitting here saying that, gee, we can't solve this problem. I am simply saying that we have the potential of losing 1 million jobs and if we do, we should work to find other methods to accomplish this objective. That is really what I am saying.

Mr. LEVIN. I applaud that sensitivity to jobs.

Mr. BRENNAN. We employ 20 million people.

Mr. LEVIN. But tell me who subsidizes those people? I mean, we are going to have to write bills. So tell me how we do that.

Mr. BRENNAN. Let me just say that the Administration bill is not understood today, and I am not sure I could write a bill. But I believe we could work with you to find ways to do so that would not take everybody up to the same level—that we can find ways to subsidize and participate in helping these part-time employees.

I don't have a definitive solution, except to say that to adopt the plan that is on the table right now is to try to solve everything at one time. I think that plan is too rich, and I think it creates the problem that we are discussing.

Mr. LEVIN. Jerry, let me just suggest, I agree with you. We are not going to solve it at one time. We are going to have to phase in solutions. But I do think there is an obligation on the part, since we are in this together, to come up with some ideas.

Mr. BRENNAN. Absolutely.

Mr. LEVIN. When you say subsidization, I think you mean somebody else paying it. And as it is, manufacturing has been subsidizing the retail industry on health. I think it has been too much, too long. So we need at some point to come up with some specific ideas.

Mr. JASINOWSKI. I just wanted to say that there is another option. And I say this only because it is an important intellectual consideration.

One way you could go is that you could mandate employers, and that is what the administration has chosen and many of our members support that. Some don't. It is a tough issue for all the reasons that have been identified here.

The other option, of course, is to subsidize the uninsured directly. And it is a very important option to consider, because I am not yet convinced which is the most cost-effective way. If you look at the small business subsidies associated with the mandate and then you extend it to retail and everything else, pretty soon you have a bill that is very large in order to legitimately protect against job loss.

If you ask how much it costs to cover the uninsured in this country, estimates I get are about \$35 billion a year. And so the notion of direct payments to those who are uninsured, however you want to do that, and there are a variety of ways to do that, is an option to consider, and there should be some judgment about which is the most cost-effective way.

So I think that intellectually I offer that up, not to push it, but just to say those are the two ways that you have got to do it.

Mr. LEVIN. I just find the notion of a subsidy generally to people who are working and where there isn't an income floor, somewhat unsatisfactory. Disconnecting the subsidy from working in terms of responsibility, accountability, eventual costs, doesn't seem satisfactory.

We need your help to work this out. I mean, just saying no won't write a bill.

Mr. BRENNAN. I think—I want to make a point. I am not sitting here saying no. What I am saying is I would like to be certain you recognize the problem and recognize as we come back with our rec-

ommendations that we have an understanding of our starting point.

Mr. LEVIN. We are anxious for that, believe me.

Mr. BRENNAN. Good. Thank you.

Mr. LEVIN. Thank you, Mr. Coyne.

Mr. COYNE. Thank you all for your testimony. The next panel is Pedro Alfonso, representing National Small Business United; Lisa Carroll, vice president of health services for the Small Business Service Bureau, Inc.; Ed Reeve, representing the Associated Builders & Contractors; and William Dunkelberg, the chief economist of the National Federation of Independent Business.

Mr. Alfonso.

STATEMENT OF PEDRO ALFONSO, MEMBER, BOARD OF TRUSTEES, NATIONAL SMALL BUSINESS UNITED, AND PRESIDENT, DYNAMIC CONCEPTS, INC., WASHINGTON, D.C.

Mr. ALFONSO. Mr. Chairman and members of the committee, I am Pedro Alfonso, president of Dynamic Concepts, as well as the CEO of several other small businesses located here in Washington, D.C.

I am an active member of National Small Business United where I serve on the board of trustees.

National Small Business United appreciates this particular opportunity. This hearing has been called primarily to ascertain our reactions to the health care reform plan of the Clinton administration, especially of its impact on the economy on businesses and on jobs.

It is worth noting that NSBU agrees with the importance of all the health care reform principles laid out by President Clinton during his presentation on the plan, especially those items that he pointed out in principle, security, simplicity, savings, choice, quality, and responsibility.

We think that our own proposal encompasses all of these principles. In fact, we think that many items from our recommendations would actually heighten the adherence of the President's plan to these principles. Given our agreement on goals and principles, it is NSBU's hope to play a constructive role in the debate and to help design a system with which small businesses can live.

We certainly think it comes down to three distinct financing options for universal coverage of a health care plan.

Have the government cover everyone. Potential option, require employers to cover all of their employees and dependents with the government picking up the rest is a second, and finally require all individuals to have coverage with the government subsidizing those who need it.

We have rejected the government-run option on philosophical and substantive grounds. We basically don't think that a government-run option totally would work.

Out of the two remaining options, we believe that an individually-based system makes far more sense for businesses, individuals, providers, and the Nation. Unfortunately, the Clinton administration has chosen the employer-based approach, and along with it an elaborate cumbersome, unequitable, and painfully expensive system of benefits for many small employers.

When all is said and done, this payroll-driven health plan, which is an employer-based mandate, is essentially a payroll tax. There are no more damaging taxes to small businesses and their employees than payroll taxes.

Of course, high payroll taxes add to the cost of current employees, increasing incentives to possibly pay lower wages and reduce the number of employees, but it also raises the hurdle for starting a new business or for hiring new additional employees.

Unfortunately payroll taxes, which is what this plan would essentially be in terms of subsidizes, are likely to increase small business failures while making the startups more costly and difficult. We should also remember that the new types of payroll taxes must be paid whether business is currently profitable or not. A highly profitable business will pay the same as one struggling to meet payroll.

And this, we feel is perhaps the greatest problem posed by an employer mandate. Its complete lack of flexibility. Under the Clinton plan, small businesses and their employees would no longer have the option of purchasing less expensive insurance in bad economic times, even if the business is quickly losing money.

Unfortunately, the major remaining areas of flexibility for the business will be lower wages and possibly jobs themselves or business failure.

This problem is one more reason we believe that the health care mandate should be separate from the workplace. The administration actually has said that the subsidy plan is an answer to small businesses. And I certainly have not been able to totally understand the subsidy program and all of its intricacies that the small businesses will go through, and I believe that the small business subsidy is almost a concoction that will add costs and probably confuse and throw the health care system, the small business economy and probably the potential of new jobs into some type of bureaucratic nightmare.

Mr. Chairman, I have a direct mail business and I would open my books up to this committee, and I would say that we are currently marginally surviving as a business, especially over the last couple of years of some turbulent economic times. We have about 60 employees and within that employee work force, we have—it is really a minority work force that is made up of mostly women, ethnic work force in terms of African-Americans, disabled, many women who are single heads of households.

And I would say that it would be very difficult for us as a business as we now provide individual health insurance to try to provide family insurance under a new plan and have that small business withstand that. And I certainly can understand how many of the single women heads of household that we have on board, many have and off of welfare. They can't afford it either, but the burden shouldn't be on our business to provide that particular social net. And it will be very difficult for us to do. But if you asked them, they would rather have a job and they would rather be able to provide for their family and themselves rather than to just give up the job because of the health care at this point in time. So I would say that society should not really shift that tax burden to small businesses for health care plans.

These payroll taxes subsidies that are being proposed are going to be hard to administer and just as hard and equitably to distribute. We feel it will only disrupt the principles of our American economy which was built on free enterprise; that is all businesses competing in an open economy.

So how would we distribute these subsidies differently? We can simply think of no way to equitably and effectively distribute health care subsidies to businesses. Frankly, we are skeptical about whether there is a way to fairly subsidize businesses for health insurance, but suggest one more reason. We have rejected employer mandate as an avenue for universal coverage. And we support the health care subsidies for individuals based upon their ability to pay.

In conclusion, Mr. Chairman, these are only a few of the serious concerns we have with the proposal as it is now planned. Others would be the lack of competition with health alliances. This forced choice solution for small business I would consider very unacceptable.

The National Small Business United wants fundamental reform of the health care system. We believe that such reform is critical to the long-term survival and growth of small business.

I will conclude by referring the committee to a report that was prepared by Arthur Anderson in conjunction with the National Small Business United and not just of NSBU's membership of 5,000, but more, about 18 million businesses, a sample that really asked the question: What would negatively impact their business. And 81 percent said increase in payroll taxes.

Thank you.

Mr. COYNE. Thank you, Mr. Alfonso.

[The prepared statement follows:]

**Statement of Mr. Pedro Alfonso
Representing National Small Business United
before the Health Subcommittee of the Committee on Ways & Means
Regarding the Economic Impact of the Clinton Health Care Plan**

November 4, 1993

Mr. Chairman:

My name is Pedro Alfonso, and I am president of Dynamic Concepts, Inc., a small business based here in Washington, D.C. I am an active member of National Small Business United, where I serve on the Board of Trustees. We at National Small Business United very much appreciate the opportunity to be here.

National Small Business United (NSBU) represents over 65,000 small businesses in all fifty states. Our association works with elected and administrative officials in Washington to improve the economic climate for small business growth and expansion. We have always worked on a bi-partisan and pro-active basis. In addition to individual small business owners, the membership of our association includes local, state, and regional small business associations across the country. For the last four years, health care reform has been our top federal priority.

This hearing has been called primarily to ascertain our reactions to the health care reform plan of the Clinton Administration, especially in terms of its economic impact. Though the Clinton Administration has now released its detailed plan, there are still some specific questions we have about the practical operation of the plan. In terms of the costs and potential savings of the plan, those are also very difficult to address without having seen specific language or heard from CBO. Nevertheless, we will react as best we can, given what we know.

Though we have many specific comments on the Clinton plan, I would like to focus my testimony today on 1) the impact of the mandate on small businesses, including the small business subsidy and payroll based premiums; and 2) the economic consequences of the system of health care alliances that the plan would establish to deal with small business' purchase of health coverage, and the need for competitive purchasing cooperatives. But, before going on, I would like to give you a picture of where NSBU is coming from on health care reform, in order to put our response into perspective.

Our plan for ensuring that all employees of small businesses (and, indeed all Americans) have health coverage has been consistent for almost three years: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage; and 3) institute a system of federal payments, based upon family income, so that everyone can afford coverage. It is a plan that responds to people, not to businesses; that responds to health care needs, not to employment status.

It is worth noting that NSBU agrees with the importance of all of the health care reform principles laid out by President Clinton during his presentation of the plan: security, simplicity, savings, choice, quality, and responsibility. We think that our own proposal encompasses all of these principles. In fact, we think that many items from our recommendations would actually heighten the adherence of the President's own plan to these principles. Given our agreement on goals and principles, it is our hope to play a constructive role in the debate and to help design a system with which small businesses can live.

Of course, the details of our plan, like everyone's, become considerably more complex. We have to deal with critical issues such as who gets subsidized, how the plan gets enforced,

what goes into a basic benefits package, how tight the insurance bands should be, and--the biggest question--how to keep a lid on costs; but all of these questions can only be addressed once we have decided the answer to the most fundamental question in this debate: Who pays?

1. The Mandate

The financing question is one of the most important in terms of determining health care reform's total economic impact. The decisions we must make on health care mirror those that must be made in terms of federal and state budgets every day. Right now, the federal government must collect over \$1 trillion annually to fund government programs. But everyone recognizes that how that money is collected--and from whom--has a far-reaching impact on our national prosperity. The same principles hold true for health care financing.

The Choices

It seems to us that we have three distinct financing options for a universal coverage plan: 1) have the government cover everyone; 2) require employers to cover all of their employees and dependents, with the government picking up the rest; or 3) require all individuals to have coverage, with the government subsidizing those who need it. We have rejected the government-run option on philosophical and substantive grounds. In addition, it is our perception that such a system stands little chance of adoption. Between the two remaining systems, we believe that the individually-based system makes far more sense--for businesses, for individuals, for providers, and for the nation.

Unfortunately, the Clinton Administration has chosen the employer-based approach--and along with it, an elaborate, cumbersome, unequitable, and painfully expensive system of subsidies for many small employers.

Problems With an Employer Mandate

Any employer-based mandate is essentially a payroll tax, but the Clinton plan makes that connection explicit by gearing premium levels to payroll levels for small employers. There are no more damaging taxes to small businesses and their employees than payroll taxes.

Of course, higher payroll taxes add to the cost of current employees, increasing incentives to lower wages and to reduce the numbers of employees. But probably of even greater importance is that these taxes would further raise the hurdle for starting a new business or for hiring an additional employee. The continuous flow of new business start-ups is one of the keys to the success of the U.S. economy. The total number of business start-ups must exceed the total number of failures in order to keep a growing small business community--and the gap between these groups is already closer than many people think. Unfortunately, payroll taxes are likely to increase the failures while making the start-ups more costly and difficult.

We should also remember that payroll taxes must be paid whether a business is currently profitable or not. A highly profitable business will pay the same as one struggling to meet payroll. And this, we feel, is perhaps the greatest problem posed by an employer mandate: its complete lack of flexibility. A survey of the small business community sponsored by NSBU and Arthur Andersen's Enterprise Group shows that small employers rely heavily upon adjustments in order to cope with health care cost increases, which averaged 22 percent in the last year. In 1993, small business owners reported that they changed to policies with higher deductibles (31 percent), changed insurance companies (22 percent), changed to policies with higher copayments (19 percent), increased employees' contributions (17 percent) and reduced the covered benefits (15 percent). While none of these choices is pleasant, they represent the sacrifices made every day in America's small businesses to keep coverage available, to keep people employed, and to keep the business open and productive.

Under the Clinton plan, small businesses and their employees will no longer have the option of purchasing less expensive insurance in bad economic times, even if the business is quickly losing money. Unfortunately, the major remaining areas of flexibility for the business will be wages and the jobs themselves. This problem is one more reason why we believe that the health care mandate should be severed from the work-place.

The Small Business Subsidy

In an admirable attempt to deal with many of these employer mandate woes, the Clinton plan attempts to help small businesses through an elaborate and extraordinarily expensive system of subsidies. Apparently, the White House has realized that an out-right employer mandate would have a profound impact on economic growth and job creation. So, they have put together a scheme designed to cushion the hit. The subsidy plan sounds simple. Businesses with fewer than 75 full-time employees would have a cap on their health care costs of between 3.5 and 7.9 percent of payroll, depending upon its average size and the size of the business. In actual practice, this system is likely to be extraordinarily complex. But, despite bill language, there are many questions to which we do not know the answers.

The administration has re-ordered the subsidies according to business size. Businesses with fewer than 25 full-time employees would get the most generous subsidy; those with 26-50 employees would receive a smaller subsidy; and those with 51-75 employees would receive still less. Businesses with more than 75 employees would receive no additional subsidy.

First, how and when is business size computed? The Clinton plan counts any employee who works more than 120 hours per month as full-time and any that works 40-120 hours per month as part-time. Employers would not be required to provide coverage for those working fewer than 40 hours per month. Of course, many businesses have employees who work greatly different hours each month. So, at the end of the year, businesses total up the number of employees who worked more than 120 hours each month, and take an average of all months in the year. From this average number of full-time employees, businesses would determine into which size category they fit and--thereby--what their subsidy rate would be.

But even once small businesses know the level of their premium caps, how do they calculate their average full-time wages, given that many employees will have fluctuated from part-time to full-time during the course of the year? Do they somehow factor-in only those wages earned by employees during full-time months, proportionally? Once these employers know their payment rate for full-time employees, they must pay a *pro rata* share of that rate for full-time employees. Determining this payment will mean reviewing all records for the previous year and calculating the proportional payment on a month-by-month basis for each employee.

The significant point is that small business owners will be making these calculations *at the end of the year*. Businesses will have been making monthly payments to the health alliance--based upon what, we do not know--during the course of the year. They will calculate their premium caps at the end of the year and determine if they are due a refund. This system reflects a complete lack of understanding about how small businesses function.

If small business owners do not know up-front what they will be paying for health care, the subsidies will not have the desired effect. Both the complexity of the subsidy calculation and its placement at the end of the year contribute to this diffusion of the subsidy's impact. First, cash flow is a perennially big problem for small businesses--especially given the small business credit crunch--and paying the full-freight every month while hoping to get a refund check at year-end will create wage and job-loss effects similar to those that would occur in the absence of a subsidy. Second, too many business owners might get caught-up in making some marginal employment decisions based upon their perceived subsidy situation--such as keeping some employees just below the full-time barrier near the end of the year to qualify as a smaller

business. This sort of behavior is not good for businesses, for employees, or for the government. And it is certainly the wrong basis for critical employment decisions.

So, how would we distribute subsidies differently? Unfortunately, we are only able to be critics of small business subsidies at this point. We can simply think of no way to equitably and effectively distribute health care subsidies to businesses. Do you subsidize the businesses that do not currently provide insurance? Tell that to their competitors who have been providing coverage and will receive no subsidy. Do you subsidize low-wage businesses--thereby encouraging low wages? Do you subsidize low-profit or low-revenue businesses? There are plenty of low-revenue businesses that are highly profitable, and there are plenty of ways to hide profits in order to collect federal dollars. Frankly, we are skeptical about whether there is a way to fairly subsidize businesses for health insurance, which is just one more reason we have rejected an employer mandate as the appropriate avenue for universal coverage. And it is one more reason that we support health care subsidies for *individuals*, based upon their ability to pay.

Moreover, the organized small business community has never asked for a subsidy. And small businesses have no confidence that the subsidy levels currently being discussed will last over the long term. Small businesses have seen every other payroll burden they shoulder dramatically increase over the years--especially Medicare and Social Security--and they are deeply skeptical that any other federal program will stay in check.

It also appears that the administration has gotten a bit ahead of itself in subsidizing the employer mandate. One of the primary reasons for considering an employer mandate has always been that significant employer financing relieves the federal government of the need to finance the care of many low-income individuals. Since an employer mandate avoids a lot of federal spending, it requires fewer new taxes and becomes more politically popular. Of course, we have a lot of trouble with a government that wants to avoid the tough choice of cutting spending or raising taxes--even for appropriate societal responsibilities--yet that insists on shifting those responsibilities to small businesses. But on a more practical level, we wonder whether the employer mandate in the Clinton plan saves the government any money at all. After all, the mandate is slated to cost about \$100 billion per year once finally phased-in, in small business subsidies alone. In its zeal to make the mandate work, has the Administration forgotten one of the fundamental arguments for an employer mandate? We think that an individual mandate could be targeted to cost less than these government subsidies to small businesses, without all of the attendant equity and implementation problems.

Individual Mandate

As President Clinton has so consistently and correctly pointed out, small business is the engine that drives job creation and economic growth in this nation. Small businesses employ 57 percent of the private work force, make 54 percent of all sales, and contribute 50 percent of the gross domestic product. In the last decade, small businesses created the vast majority of new jobs. Yet, we also have to remember that small business jobs are more likely to be filled by younger workers, older workers, women, and part-time workers. Unfortunately, a health care mandate that drains tens of billions of dollars out of small businesses every year will put a dramatic damper on job creation and economic growth, affecting those workers and the businesses that employ them most of all.

Please understand where we are coming from: an individual approach is not an attempt by small business to duck responsibility for the health of their employees; over 80 percent of small business employees and their dependents have insurance. An individual mandate will not cause those businesses currently providing insurance to drop it. In fact, we think that requiring all individuals to participate in the system would actually increase the pressure that employees place on their employers to provide that coverage for them, causing employer-provided coverage

to increase. Yet, there are situations where the added expense of health insurance would cause wage deflation, lost jobs, and even business closings. A system that responds to the needs of the employees and families of such businesses--on an individual basis--would be the best system. As important as it is to provide access to quality health care for all, we think that employment and jobs should receive equal attention, especially when there is a conflict between these two needs.

II. Health Alliances

The health alliances are a critical piece of the Clinton plan, funneling hundreds of billions of dollars from business and individuals to health care plans. Run improperly, the alliances have the power to produce real economic harm. Run well--within a competitive framework--purchasing cooperatives could save money and promote economic well-being.

Single, Regional Alliances

Under the Clinton plan, all employees of businesses with fewer than 5,000 employees would be enrolled in their regional health alliance, to which their individual and employer premiums would flow. Once in the alliance, the individuals would choose from the various health plans that qualify to be offered by the alliance. At no point in the process are small employers, who will be paying most of the bill for their employees, given a choice or allowed any avenue to find a better value for their money--and they are certainly not given the chance to actually save money. By for-going the use of competitive forces at the health alliance level, the Clinton Administration is missing a major opportunity to save money and make the plan more economically viable.

Under the Clinton plan, the health alliances will have far-reaching responsibilities--from enforcing budgets to delivering provider information to individual members. It seems unlikely that this large and busy bureaucracy will find creative ways to encourage competition and innovation. There may need to be some sort of "health alliance" at the local level to coordinate provider expenditures and provide a framework for community-wide health care decisions. But these roles should be separated from the purchasing cooperative role, which is simply to bring businesses together to bargain for the best deal on coverage for their employees. Unfortunately, this dynamic cannot occur in the Clinton plan.

How are we to bring competitive forces to bear for cost containment when those who are paying are not allowed to make any choices for their dollars?

Competing Purchasing Cooperatives

Small businesses should have the right to organize and run their own health care purchasing cooperatives, in order to have choice and empowerment within the system. A mandate on employers which provides neither an avenue for these businesses to choose how to purchase coverage nor an ability to organize for their own best interests and survival will be very unpopular with small business. Many businesses which currently provide coverage, and might not oppose an employer mandate, will almost certainly oppose a provision which traps them into purchasing coverage from a single--potentially inefficient--source.

Moreover, we believe that private competing health alliances are essential for maximizing competitive forces for cost containment. Competing cooperatives will have strong incentives to negotiate tough deals with providers, in order to attract members. In areas where the market cannot sustain multiple cooperatives, they will not exist, thereby maintaining the efficiencies of larger pools. Multiple cooperatives represent an important component for maximizing the cost containment potential of managed competition.

The Administration has been appropriately nervous about allowing single, monopolistic (and monopsonistic, depending upon your point of view) health alliances to exclude health plans from participation in the alliance. The only mechanism the alliances would have to exclude plans would be a price cap and several other objective standards. But competing alliances could actually bargain with insurers and provider groups for the best deals for their members, and groups that would not deal could be excluded from the alliance. The competing alliances' ability to exclude insurers and provider groups would be one of their most powerful cost containment tools.

The Administration's plan allows large corporations with more than 5,000 lives to opt out of the health alliance system and self-insure. They will only do so if that action enables them to save money. Small businesses are given no similar opportunities to find cost savings in the system. Small businesses need this kind of flexibility even more than their larger counterparts. Moreover, even in a system of competing health care purchasing cooperatives, we believe that the ceiling for business participation should be much lower than 5,000 lives.

Risk Selection

Some opponents of competing health cooperatives have argued that competing health alliances will foster adverse selection problems, causing many of the plans to descend into a doomed "death spiral." We simply think that these arguments are somewhat overblown and should not be viewed as an insurmountable problem. If all individuals must have coverage, and all providers and alliances must offer coverage and accept individuals under the same conditions, we believe that the risk selection problems will be relatively minor.

But, if necessary, there are several ways to deal with potential risk selection problems in a competitive purchasing cooperative environment. Since adverse selection has primarily to do with individuals "gaming" the system for their own benefit (sick people enrolling in the most expansive plans and young healthy individuals choosing HMOs), we expect most risk selection problems to occur *within* the purchasing cooperatives, rather than *between* them. Within the purchasing cooperatives a risk adjuster could be used, similar to that which the Administration plans to use in their health alliances' health plans, which will have the same problems. Such a risk-adjuster would essentially allow insurers to insure against having too many unhealthy individuals in a plan. This mechanism will spread the costs of caring for the sick equitably across all carrier groups.

In a system of competing health purchasing cooperatives, businesses would be making the decisions about which cooperative to join, so the individual risk selection problem would not exist. Any risk selection would occur from the relatively subtle marketing decisions of the purchasing cooperatives. For instance, purchasing cooperatives could choose to only market their services to "better risk" businesses in better risk areas--assuming these non-profit entities were wily enough to have that knowledge. But it would be relatively simple to circumvent this problem by informing all businesses of all purchasing cooperatives which are available, along with a thorough description. And if cooperatives attempt to serve one part of a region differently than another, it would be easy enough for the states to draw boundaries in a way to make this practice at least very difficult.

Again, competing purchasing cooperatives are likely to provide greater cost containment than single alliances; competing cooperatives can be structured to avoid risk selection problems at least as well as single health alliances; competing cooperatives provide small businesses with empowerment in the system, room to maneuver without feeling "locked-in", and a role in keeping costs down system-wide. We think that the issue of competing purchasing cooperatives will ultimately be one of the key small business issues in this debate, unless it is addressed early-on.

III. Conclusion

National Small Business United wants fundamental reform of the health care system; we believe that such reform is critical to the long-term survival and growth of small businesses. But the new system must make economic sense, and it must take the unique needs of small businesses into account. As you might guess, we have many other comments on many other aspects of the Clinton plan. If there is any further input that we might be able to provide to the Committee, we will be pleased to do so. Thank you.

Mr. COYNE. Ms. Carroll.

STATEMENT OF LISA M. CARROLL, VICE PRESIDENT OF HEALTH SERVICES, SMALL BUSINESS SERVICE BUREAU, INC., WORCESTER, MASS.

Ms. CARROLL. Good afternoon and thank you for inviting me to testify today on the impact of the Clinton health reform plan on the small business community. My name is Lisa Carroll. I am the vice president of health services for the Small Business Service Bureau, which is a national membership organization representing more than 35,000 small businesses.

Most of our members are self-employed, sole proprietors, partnerships and unincorporated businesses. One of the roles of Small Business Service Bureau is to act as a sponsor for health insurance programs for these small companies. We pool them into a larger group which does promote marketing and administrative efficiencies and premium stabilization. SBSB members do agree with the President that the time has arrived for resolving our Nation's health care problems and we applaud his leadership in bringing this issue to the forefront of the national policy debate.

We also agree with his principles of simplicity, savings, quality, choice, responsibility, and security, but are concerned about the sacrifice required to achieve these objectives; that the sacrifice will be borne by the small business community in the form of higher premiums, higher prices for that when we buy and sell and higher taxes.

As you have heard today, the imposition of the employer mandate to contribute 80 percent to the cost of insurance will place an enormous financial burden on many small firms. Anecdotal evidence from local employers implies the figures currently estimated by the administration will be higher.

Even with the government subsidies, small employers have stated they will raise prices, fire part-time workers and lay off higher wage earners to be replaced by lower wage earners. The health industry, along with restaurants and temporary agencies, have been responsible for 60 percent of employment growth in the last 30 months. Yet even the health care industry is laying off right now, and in any major metropolitan city you hear of direct care givers, nurses, being laid off by hospitals as hospitals respond to an increased squeeze on Medicare and Medicaid reimbursement.

I think State and local taxes will also increase as legislators themselves struggle to raise revenue for health insurance coverage for State and local government workers. This cost has not been taken into consideration in the overall cost of the Clinton program.

Small businesses are also wary of the permanence of the 7.9 percent payroll cap and the availability of subsidy funds. Already between the proposal being announced and the final plan issued last week, the subsidy levels have changed. How many more times will that subsidy structure change and what will the cap be on total funds available?

If all Americans are to be entitled to health insurance, then it should be the responsibility of individuals to obtain such insurance. A subsidy program based on individual income would be more consistent with existing government systems of appropriation and ad-

ministration. Right now, according to MIS specialists, there is no system available to even manage an employer-contribution type program.

However, as this committee has so aptly pursued today, the impact of the Clinton plan on jobs in the economy goes a lot deeper than just the philosophical debate about mandated coverage. The cornerstone of the plan, which is the purchasing alliance, will have many hidden costs which will increase the amount of money needed from small employers to support the system.

They (purchasing alliances) have no incentive to be efficient or innovative, and they will require increased taxes and fees just to support their infrastructure and operations. Alliance members, primarily the small business population, will be responsible for subsidizing the costs of older, sicker workers and early retirees from large corporations and union trusts which are dumped into the alliance pool. However, larger corporations and self-insured plans that have a healthy, young work force are allowed to continue self-insurance and experience rating.

Adding this older group of people to the alliance pool will increase the average cost of coverage for all other participants because it will raise the community rate. Thus small employers will be required to contribute 80 percent to artificially inflated premiums.

Alliances will also create an administrative burden for employers. For example, if the alliance requires a risk adjustment system for premiums based on health status it will need a health statement from every member at the time of enrollment. This increased paperwork does increase cost.

Given the volume of employers who obtain insurance through the alliance, the increase in paperwork just to get into the system will be enormous. Alliances will also be responsible for determining subsidy levels.

According to the Clinton plan, small employers will be required to enroll new employees within the first 30 days of hire. Can the Federal Government guarantee that the timing for the application of and allocation of subsidy funds will match up with the requirement for employers to enroll employees into the alliance? If it doesn't match up, there will be a significant restraint on cash flow for small employers that are required to pay in within a certain amount of time, but don't get the subsidy money on the back end to support enrollment of their employees into the program.

Then, once the employee is in the system, coverage cannot be canceled for nonpayment. That means the alliance will have to pick up the burden for nonpayers, shifting this cost to existing alliance members that do pay, and possibly delaying remittance of funds to health plans for actual delivery of services.

I have reviewed this situation to find out how it could be changed. The only conclusion I can reach is this will represent the 21st Century version of uncompensated care. Uncompensated care won't go away; it will just take on a new form.

My belief is the purchasing alliance in the Clinton plan is a big business solution to a small business problem that big corporations created when they opted out of the fully insured market to self-insure. Cost shifting first started with Medicare and Medicaid, then

back in 1975, when ERISA was passed—I think that is the date—large employers opted out of fully insured pools, which then created a problem in the marketplace for insurers. That is when they started to cherry pick and cause further segmentation of the small group market.

I believe that all insurers should be required to offer a standard benefit plan to small employers and that all businesses should be prohibited from experience rating and self-insurance. Instead of creating new artificial pools just put everyone back into the pools that we already had to begin with.

We encourage legislators to engage in an honest debate about how much the health reform plan will cost and how this revenue will be generated. Inflated premiums, hidden fees, unanticipated State and local tax increases and additional administrative costs must be factored into the equation. And before a solid estimate can be made about the impact of health reform on America's small companies, its true cost must be revealed.

I think we should also look at the experiences of other governments in relation to mandated employment benefits. Germany is the system off which most of the Clinton plan is modeled. However Germany is experiencing record unemployment and is considering moving to a 4-day workweek, just to avoid further job cuts. And in today's Wall Street Journal there is an article on how Germany is trying to slash compensation programs in order to save jobs.

Finally, I believe elected officials, and not an appointed regulatory board, must be accountable to the American public for the financing of this program. Thank you.

Mr. COYNE. Thank you, Ms. Carroll.

[The prepared statement follows:]

Statement of Lisa M. Carroll, R.N., M.S., M.P.H.
 Vice President, Health Services
 Small Business Service Bureau, Inc.
 Worcester, Massachusetts
 U.S. House Committee on Ways and Means
 Subcommittee on Health
 Health Care Reform: Impact on the Economy and Jobs
 November 4, 1993

Good afternoon Representative Stark and members of the Subcommittee on Health. I appreciate the invitation to speak to you today on the impact of the Clinton health reform plan on the small business community.

My name is Lisa Carroll. I am Vice President of Health Services for the Small Business Service Bureau, Inc. (SBSB). SBSB is a national membership organization representing more than 35,000 small business member firms. SBSB was founded, and exists, to provide legislative advocacy, management assistance, and group benefits and services to small companies employing fewer than twenty-five people. Most of our members are self-employed, sole-proprietorships, partnerships, and unincorporated businesses. One of the most vital services offered to small business members is access to group Blue Cross Blue Shield and HMO programs. SBSB pools the small companies into a larger group, which promotes marketing and administrative efficiencies and premium stabilization. SBSB's sponsorship activities are similar to those of the purchasing alliances included in many of the reform proposals under debate on Capitol Hill.

SBSB members agree with the President that the time has arrived for resolving the nation's health care problems, and applauds his leadership in bringing this issue to the forefront of national policy debate. We agree with his principles of simplicity, savings, quality, choice, responsibility, and security, but are concerned the sacrifice required to achieve these objectives will be borne by the small business community in the form of higher premiums, higher prices, and higher taxes.

The imposition of an employer mandate to contribute 80% to the cost of health insurance will place an enormous financial burden on many small firms. Administration officials estimate job loss at 600,000 nationally, however anecdotal evidence from local employers implies that figure will be higher. Even with government subsidies, many small employers have stated they will be forced to raise prices, fire part-time workers, and lay-off higher wage earners to be replaced by lower paid workers. The 80% contribution level is higher than what most businesses currently pay, and includes part-time and seasonal workers employed for as little as 10 hours a week. There is no question that the cost of starting and operating a business will increase. In addition, state and local taxes will increase, as legislatures struggle to raise revenue for the health insurance coverage of government employees.

Small businesses are also wary of the permanence of the 7.9% payroll cap and the availability of subsidy funds. Experience with Medicare and Medicaid funding has demonstrated that as the cost of entitlement programs increases, payroll contributions increase and benefits and subsidies are cut. Already the Administration has restructured the subsidy program for small, low-wage firms.

If all Americans are to be entitled to health insurance, then it should be the responsibility of individuals to obtain such insurance. America's small companies should not be the passive financers of insurance, but should be encouraged to structure their employee benefit programs to meet both the needs of their work force and the bottom line for economic and competitive survival. A subsidy program based on individual income would also be more consistent with existing government systems of appropriation and

administration. The management information systems needed to administer an employer mandate have not yet been developed, and the process itself will be complex, time consuming, and expensive.

The impact of the Clinton plan on jobs and the economy goes much deeper than the philosophical debate about mandated coverage however. The cornerstone of the plan, the regional purchasing alliances, will have many hidden costs which will increase the amount of money needed from small employers to support the system.

The purchasing alliances proposed in the Clinton plan will increase system costs because they will be bureaucratic agencies with a monopoly on the health care market, having no incentive to be efficient and innovative, and will have the power of managing more money than most state budgets. The Clinton plan would put 99.9% of all employers and 70% of all workers into the hands of a government regulated body. In addition to the taxes and fees needed to support the infrastructure and operations of the alliances, alliance members, primarily the small business population, will be responsible for subsidizing the costs of older, sicker workers and early retirees from large corporations and union trusts which are "dumped" into the alliance pool. Adding this older group of people to the alliance pool will increase the average cost of coverage for all other participants in that pool. Small employers will thus be required to contribute 80% to artificially inflated premiums.

Alliances will create an administrative burden for employers. If an alliance risk-adjusts premiums based on health status, it will need a health statement from every member at the time of enrollment. Medical underwriters who have traditionally screened risk for denial of health insurance will now become "risk adjustment assessors". Given the volume of employers obtaining insurance through the Alliance, the increase in paperwork just to get into the system will be enormous. Employers will also have to track individual employee choice of health plan and calculate contribution levels according to payroll. This will be a dynamic and continuous process, requiring development of new payroll withholding systems which all employers will have to subscribe to.

Alliances will also be responsible for determining subsidy levels. Small employers are required to enroll new employees within the first 30 days of hire. Can the government guarantee that the timing for application and allocation of subsidy funds will occur within that same time period? If the administration of subsidy funds takes longer than that required of the employer for enrollment and payment of premium, the firm's cash flow will be severely constrained. Once the employee is in the system, coverage may not be cancelled, even if the employer fails to pay. The Alliance will pick up the burden for non-payers, possibly delaying remittance to the health plan, which then must deliver services to those utilizing the system who have not paid into it. The burden of non-payers will be shifted to other alliance members and taxpayers.

Alliances will have their own, updated version of uncompensated care.

There are 7 million companies of 1-100 in this country, and only 2,400 corporations with over 5000 employees. The purchasing alliances proposed in the Clinton plan are clearly a big business solution to a small business problem which they themselves created by pulling out of the fully insured market. Instead of creating new pools of employers and employees, self-insurance should be prohibited and all firms should be required to participate in fully insured, community rated plans. And all insurers should be required to offer a standard benefit plan to small employers consistent with the principles of small group market reform.

SBSB encourages legislators to engage in an honest debate about how much health reform will cost, and how this revenue will be generated. Inflated premiums, hidden fees, unanticipated state and local tax increases, and additional administrative costs should be factored into the equation. Before a solid estimate can be made about the impact of health reform on America's small companies, its true cost must be revealed. We should also look at the experiences of other governments in relation to employment benefits. The German system was the model for much of the Clinton plan, yet Germany is experiencing record unemployment and is considering moving toward a four-day work week to avoid further job cuts. Finally, elected officials, not an appointed regulatory board, should be held accountable for financing decisions.

Mr. COYNE. Mr. Dunkelberg.

STATEMENT OF WILLIAM C. DUNKELBERG, PH.D., CHIEF ECONOMIST, NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Mr. DUNKELBERG. Thank you, Mr. Chairman, committee members. My name is William C. Dunkelberg. I am here as chief economist of the National Federation of Independent Business which has over 600,000 member firms nationwide. I am also the dean of the school of business and management at Temple University and this year I am serving as president of the National Association of Business Economists. I don't represent their views, however, here at the table.

We have had a lot of discussion today in the committee about many technical aspects of the bill as it has been proposed. And I would like to take a step back from there and ask some philosophical questions. I think it is great that the President and Congress are focusing on some of the problems that we have in health care and that they are setting some admirable goals for us to pursue, but I am concerned philosophically about the mechanisms which the bill is going to rely on to get this job done. The bottomline is, we don't think that it will get the job done.

Let me raise a few fundamental points. First, it seems that it is suggested that we have a crisis in medical care because we now spend 12 percent of our GDP on health care. I would like to point out that we spend 12 percent of our GDP on health care because consumers choose to spend that much money on health care. It is not being forced on them. It is not being spent by somebody else and attributed to them. It is done by their choice.

We might also look at the percentage of GDP going to housing or automobiles or whatever, and maybe declare a crisis there. I would hope we wouldn't and I hope we wouldn't propose a government bureaucracy to control expenditures in those areas.

The second point that I think is very important is that we have a system that is based on private responsibility. That is, you and I as individuals are given the responsibility to get food, clothing, housing, transportation, or whatever. And then for people who are not successful by whatever standard that we might set of acquiring these things for themselves, we do provide some help. But the administration's proposal really turns this whole thing upside down taking upon it the responsibility to acquire this commodity for all Americans, and proposing a kind of one-size-fits-all approach to this market. And that certainly flies in the face of what we know to be a successful way to run an economy and to deliver goods and services to consumers.

Now, there seems to be a few fundamental assumptions on the part of drafters of this program and the administration officials that we ought to take a look at. One is that it is fairly clear that many administration officials feel that businesses are not sensitive to changes in labor costs and that they really won't respond to this.

We have seen this debated today, so I can't add a whole lot to it except to point out if you employ 10 to 20 people and you go from zero cost to 2,400 per, that is going to be a big change. We also have this bracketing so that is a company that has 25 employees

and a 3.9 percent cap, the 26th employee not only costs the wage you have to pay that employee but 2 percent more of the accumulated wage base of the first 25 employees that you hire. So you have some tremendous disincentives to let your firm get any larger. That is not very effective. There is a heavy reliance on price controls in this proposal and that is not good either. It has never worked in the past and it certainly is not going to work here. And I would suggest to you with a simple story why this isn't going to work.

Suppose the price of corn doubled this year and corn farmers made a lot of money and this winter we would have corn farmers saying we are going to plant a lot of corn and wheat farmers saying I am going to go for corn instead of wheat. And next year we might get a lot more corn and if we did, the price of corn would come down. But if the Congress determined that it appeared corn prices were excessive and put price controls in on corn, it would never happen. And that is what is in this proposal.

We want to add 30 to 50 million new demanders. We have the baby boomers going through and at the same time we are going to put price controls on the system to discourage people from entering the business, to discourage people from becoming doctors and health care professionals and discourage firms from providing services. That doesn't make sense conceptually to me and I have a real problem with that.

There is another big flaw here and that is that we are confusing insurance with prepaid medical care. And let me give you a simple example. Suppose I can take my car to the local gas station any time for any kind of thing it needs, free lube, free oil change, free painting, free this, free that. If I don't like it, what would my automobile insurance premiums look like in a situation like that? The answer is they would look like health care premiums.

Insurance is one thing. That protects us from having health care problems wipe us out financially, but prepaid medical care is incredibly expensive. It is not the responsibility of government, in my opinion, to provide prepaid health care as a product to all American citizens. We need to have a little bit of choice here.

Finally, I would suggest that there is a major inconsistency in all the objectives that have been set out for us by various administrative officials. Chairman Tyson said this was the objective of the administration to lower the percentage of GDP going to health care. I guess that is the case since they called 12 or 13 percent a crisis.

We have had Ira Magaziner tell us that the vast majority of Americans are going to pay less and get more. Right away we have a major inconsistency, especially if we are adding 30 million plus new users and we have to handle the baby boom as it gets older over the next decade. I see major inconsistencies here in policy objectives and I think that will result in a failure in program as well.

I think we ought to think back about what our responsibilities are here and whether or not the fundamental approaches to this problem as proposed in the President's bill can, in fact, accomplish anything close to what the sponsors of the bill hoped to achieve. Thank you very much.

Mr. COYNE. Thank you Mr. Dunkelberg.

[The prepared statement follows:]

**STATEMENT OF DR. WILLIAM C. DUNKELBERG
CHIEF ECONOMIST
NATIONAL FEDERATION OF INDEPENDENT BUSINESS**

Thank you for this opportunity to testify before the Subcommittee on Health on the important subject of the economic impact of the President's health reform package. The National Federation of Independent Business (NFIB) is the nation's largest small business advocacy organization, representing more than 600,000 small and independent business owners nationwide. My name is Dr. William C. Dunkelberg and I am the Chief Economist for NFIB.

We have become wealthy enough as a society to begin talking about health care as a "right" of our citizens, not something to be bought after the basic necessities of food, clothing and shelter have been paid for. We are, however, philosophically treading on new ground with the Administration's health care proposal. For most Americans, securing shelter, food and clothing is a private endeavor. For those who are not successful at attaining the minimum acceptable levels of these necessities, the government steps in to assure that their basic needs are met. Yet, the Administration wants to "take over" the provision of health care for every American.

Originally, each American was to have been guaranteed [compelled to take] a basic health care program. The amount spent on health care was to be reduced simultaneously. As CEA Chairwoman Laura Tyson noted, it was the Administration's objective to reduce the total percentage of GDP spent on health care while at the same time guaranteeing a standard package to some 37 million Americans without health insurance and millions of others judged not to have adequate care. Administration officials promised that most Americans would pay less for the same or better health care. This is quite a feat! Although it appears that the Administration is backtracking, even in its most recent form the proposal represents an incredible shift in governmental involvement in private lives. To date, there is no evidence that any such undertaking has ever been successful in the U.S.

Before looking at some "details", I would suggest that the program is flawed both philosophically and conceptually. The designers have created, through assumptions, a world for their health care program that is not real and not like the world we live in. I would offer a fable about a wheat farmer that I hope illustrates some of these flaws:

After planting his wheat as he had done for many years [because wheat grew better on his land than any other crop], the farmer heard rumors that for some unknown reason corn demand was soaring and corn futures were rising. But, wheat still looked good and he had already planted.

At the end of the season, he harvested his wheat and made his usual profits -- enough to keep the farm going next year. By then, corn markets had gone wild. Corn prices had doubled and corn farmers had made a killing. Analysts expected corn demand to be equally strong again next year.

The wheat farmer decided to plant corn next year. After all, he had good land and it could do well in corn production. Wheat had been more profitable than corn for his farm in the past, but these new corn prices made corn the best bet.

When planting time came, however, the farmer read that Congress judged corn farmer profits to be "excessive", and had passed a law limiting corn prices to prior year levels and taxing "excess corn profits". At that point, there was no incentive for the farmer to plant corn, so he planted wheat as he had always done. All the next summer, corn products were in short supply in the stores. Newspapers reported daily on various schemes and illegal acts involving consumers and distributors that produced higher actual prices for corn products along with lines in the grocery stores.

Left alone, the market would have produced more corn and would have lowered prices, providing more corn to meet the demand of consumers and at reasonable prices. With price controls and profit taxes, the shortage was perpetuated indefinitely to no one's benefit except sharp operators and government bureaucrats.

The Administration wants more health care for more people, but wants to control prices and profits. This is the recipe for massive failure that will cripple the quality of health care received by Americans. The objective here is to expand the supply of health care services while bringing prices down. Only markets can accomplish this task -- not governments.

The Administration observes that Americans buy a lot of health care and calls this a "problem". It observes that the price of health care services rose substantially above the CPI throughout the 1980s [it is trending down now] and calls this a crisis. No attempt is made to fix the parts of the system that aren't working well [most due to government intervention in the private market]. Rather, the entire system is to be scrapped and there will be little relief for the "targets of concern" for years.

THIS IS CONCEPTUALLY THE WRONG WAY TO APPROACH THE PROBLEM. IT IS BASED ON GOOD MOTIVES BUT ALSO ON ASSUMPTIONS THAT HAVE BEEN PROVEN AGAIN AND AGAIN TO BE UNFOUNDED AND MISGUIDED.

Another conceptual confusion in the Administration plan: the Administration confuses the notion of INSURANCE and PRE-PAID MEDICAL CARE. Look at automobiles and auto insurance. We are privately responsible for deciding how expensive a car we will buy and for paying for its maintenance. Only if there is an "unexpected event" -- an accident -- does insurance cut in and then only for amounts above a specified deductible. In short, insurance protects us against financially ruining events, but it does not cover the daily maintenance of our cars. Imagine insurance premiums if we simply drop the car at a garage for maintenance with no charge for each visit. What color fits your mood this week? Unhappy with the little scratch on the fender? Repaint it. Insurance will take care of it. Would we avoid larger repairs [the loss of a transmission] with more "preventive care"? Maybe. The evidence is not clear. But why spend time "preventing" if the cost of replacement is covered?

The Administration is clearly selling us PRE-PAID MEDICAL CARE, not insurance. This is very expensive. Basic INSURANCE that protected families from ruinous medical bills is not relatively expensive. But the Administration has far more in mind. The White House believes that \$2000 deductibles should be eliminated [Ira Magaziner, the Press, 10/31/93]. They believe young people should pay more and older people should pay less [despite the fact that citizens over 65 are much wealthier than the under 25 sector]. They believe those who are presently uncovered will engage in preventive care that will be more than offset by savings in later years.

The Administration also believes that the cost of labor does not impact the hiring decision. This means you can tag the employee [and prospective employee] with the cost of the program and deny that there will be negative employment effects. No decent economist will argue that raising the cost of anything will get anyone to take more units of it! If studies show that employment rises after an increase in the minimum wage, it simply reflects the inadequacy of our models and econometric techniques in controlling factors that cause firms to hire more labor when wages rise. Indeed, just as interest rates are relatively high when investment is high [because the demand for funds is strong], so we should not be surprised to see wages and employment rising together for periods of time.

I believe that the drafters of this plan made many flawed or incorrect economic assumptions:

- * IT IS CLEARLY THE POSITION OF THE ADMINISTRATION THAT HIGHER LABOR COSTS WILL NOT PRODUCE INCENTIVES TO REDUCE EMPLOYMENT AND CREATE FEWER JOB OPPORTUNITIES. This is not true in the world we live in.
- * THE ADMINISTRATION GENEROUSLY FORECASTS THE FUTURE GROWTH IN MEDICARE AND MEDICAID IN ORDER TO SHOW MASSIVE SAVINGS TO BE GAINED BY THEIR PROPOSED SYSTEM. They overestimate growth and ignore the past.
- * THERE ARE VERY LARGE NUMBERS OF "UNINSURED" THAT WILL NEVER CARRY A HEALTH SECURITY CARD, NEVER GET PREVENTIVE CARE AND WILL CONTINUE TO "SHOW UP" AT OUR MEDICAL CARE FACILITIES WHEN THEIR CONDITION IS CRITICAL. The program assumes this problem will completely disappear.

- * THE ADMINISTRATION MAKES CLAIMS FOR THE FUNCTIONING OF HEALTH CARE BUREAUCRACIES THAT ARE TOTALLY DIFFERENT THAN ANYTHING WE HAVE EXPERIENCED IN THE PAST. Based on previous experiences, we know that government health care bureaucracies do not operate this way.
- * THE ADMINISTRATION WILL TRY TO SHIFT THE COST OF ITS PROGRAMS ONTO NEW STATE BUREAUCRACIES, MISLEADING THE PUBLIC ABOUT THE SIZE OF THE FEDERAL DEFICIT. Once again states may find themselves covering for over ambitious federal government programs.

The Administration has two major concerns: [1] universal coverage and [2] cost reduction. It can mandate the first, but has proposed little that will produce cost reduction in any real sense. And instead of dealing directly with the real problems, some solutions are deferred for years while we try to restructure the entire industry to conform to an unrealistic world created by the designers of the proposal.

From an economic perspective, here are some realities to deal with:

- Attaching new health care premiums to employees will destroy future job opportunities and discourage employment. Any new jobs created in the health care industry will require different skills and training than held by those who lose jobs. Controls on prices and profits will discourage people from getting the needed training.
- Employment costs include wages, state assessments [like unemployment taxes], social security, and any other benefits. If the benefits are increased by mandate, the take home pay will be appropriately reduced.
- A payroll tax will explicitly discourage firms from hiring employees. These higher costs will be passed on in the form of higher prices to consumers, disguising the tax being imposed by Congress.
- If the cost of the payroll tax is simply passed on in higher prices, it becomes the equivalent of a sales tax. As a result, many say why not use a sales tax directly? The rich will pay more than the poor, everyone will pay something, and no new revenue bureaucracy is needed.
- Until consumers have direct control over health care outlays, we can't get the cost under control. I have first dollar coverage. Nothing I do can reduce my monthly premium and everything is "free". This maximizes national costs.
- If the cost of health care is truly reduced, people will want to take more of it. This will increase total outlays.
- If benefits were treated as ordinary income, firms would simply give each employee their health care dollars and individual consumers would choose their own health care programs, just as they buy auto and home insurance.
- The most inefficient health care programs are currently run by government
- The worst red tape and complicated forms are those for programs run by the government
- A reduction in the remuneration for health care professionals such as nurses will reduce the number of people electing these careers.

Although well motivated, the Administration's plan does not deal with the incentives and the behavior that drive health care outlays. The main reason that health care expenditures are 12% of GDP is that consumers choose to make these outlays.

If they spend "too much" and/or receive "too little" value, it is because consumers do not directly participate in financing the cost of care and their behavior has little or no impact on their premiums. Let consumers pay for routine medical care as they pay for everything else in life. Let insurance protect them from "large" costs. Make coverage universal and portable for a standard benefit plan [that is insurance, not prepaid medical care]. Finance the plan through a broader mechanism that will let everyone contribute something, but will not give firms incentives to reduce employment in order to manage medical costs. Let's attack the identifiable goals straight on and change the aspects of the current system that produce uncompetitive behavior. This will bring immediate relief to those who allegedly have no coverage and will spare us the agony and inefficiency that the proposed new government monopolies would create in the years to come.

Mr. COYNE. Mr. Reeve.

STATEMENT OF ED REEVE, SENIOR VICE PRESIDENT, TD MECHANICAL, DALLAS, TEX., ON BEHALF OF ASSOCIATED BUILDERS & CONTRACTORS, INC.

Mr. REEVE. Thank you. My name is Ed Reeve. I am senior vice president of TD Mechanical in Dallas, Tex. I am pleased to speak to you on behalf of the Associated Builders & Contractors. We are a national organization with nearly 16,000 members who work in every facet of the construction industry and who are, for the most part small, employers.

I have submitted written testimony for the record and so will summarize with my verbal remarks this afternoon.

I always enjoy my trips to Washington. It is a great city and I enjoy running in the city in the early morning. This morning I did so. I found myself on Roosevelt Island this morning and while there I found the memorial to Theodore Roosevelt, and on one of the stones was this inscription: "Popular government results worth having can be achieved only by men and women who combine worthy ideals with practical good sense."

Our association supports the basic tenets of the President's proposal: Security, simplicity, savings, choice, quality, and cost sharing. But we are troubled by some of the methods used to reach this lofty goal.

According to a personnel administrative services survey of 1,000 merit shop contractors, the vast majorities of construction companies are providing health insurance for their employees. In fact, more are doing so now than 5 years ago. Depending on the volume of the companies surveyed, from 71 percent to 95 percent are providing health care coverage. These statistics clearly indicate that contractors are trying to take care of their workers. They are customizing their benefits to the local conditions and the unique characteristics of the construction work force.

I believe any health care reform must reflect the realities of the workplace and flexibility is crucial for the construction industry.

One of the things that we disagree with in the President's plan is mandated coverage. Under employer mandates, employers no longer have the flexibility or opportunity to design plans suited to the needs of their employees working in a specific industry. Businesses would no longer have incentives to control their costs.

The employers lose control of their individual costs when put in a regional alliance. The intent for establishing alliances under the original concept was to provide small employers, who account for the majority of the working uninsured, with a way to pool their numbers and purchase coverage on same basis as larger employers.

Let's go back to that original intent. As an example of a principle that I believe does work, I would like to share with you some of the things that have been done in my own company. We are a company of approximately 600 employees. We are employee-owned and we have initiated a very aggressive health care program in our company.

Four years ago our health care costs were increasing at a rate prevalent with the health care industry; in our case costs in our region up to 15 to 20 percent for year. Four years ago we decided to

take a more active role in providing health care cost control within our company and we established a health care quality team.

I might say our company is also very involved with the total quality management process and this is an offshoot of that.

For 4 years, including the three-fourths just completed of 1993, we have reduced and maintained our total health care costs to our population. Our annual total cost for health care coverage currently is \$2,400 per year, almost \$1,100 dollars less than the lowest average for medical benefits in our market area. To do this, we have had an aggressive education program. We have practiced what we think is very proactive medicine to keep our population more aware of lifestyle effects on health care costs.

We have initiated a smoke-free environment, which extends to our job site construction trailers. We have financed smoke cessation plans to help those individuals that wish to quit smoking to do that. We are very committed to helping our work force live healthy and more productive lives. We have created incentives for our employees and they know we are in this together.

Our association, Associated Builders and Contractors, also believes that employer mandates destroys the motivation for businesses to take charge of their own health care costs. To assist contractors in taking charge of their cost, ABC provides a variety of cost containment incentives, as well as a variety of health care plans.

A menu of benefits are offered from the traditional fee-for-service to PPOs and HMOs. ABC has made available unique benefit programs that provide coverage for hourly workers. Our association provides an alternative, whereby employers can contribute to the cost of coverage for our employees who are considered less than full-time and would normally not be eligible for insurance coverage.

Portability of coverage from one area of the country to another is enhanced through this system by the availability of nationwide programs such as ABC's. Under the administration's proposals both our individual company program and our association's program would be eliminated.

We very much support health care reform as a worthy and lofty goal for our society, but we are very concerned about the mandated portions of this coverage as being cost prohibitive to our companies and our members. I appreciate the opportunity to appear before you this afternoon and would be happy to answer any questions.

[The prepared statement and attachment follow:]

**STATEMENT OF ED REEVE
SENIOR VICE PRESIDENT, TD MECHANICAL
ON BEHALF OF
ASSOCIATED BUILDERS AND CONTRACTORS**

Mr. Chairman, members of the Subcommittee, thank you. My name is Ed Reeve, I am a Senior Vice President at TD Mechanical in Dallas, Texas. I am pleased to speak to you today on behalf of Associated Builders and Contractors (ABC), a national organization with nearly 16 thousand members who work in every facet of the construction industry and who are, for the most part, small employers.

ABC is a representative of small business, a sector of the economy that has already received a great deal of attention in the current health care debate. As the committee has heard many times, small business has been hit particularly hard by rising health care costs. Although ABC supports the basic tenets of the President's proposal - security, simplicity, savings, choice, quality and cost-sharing, we are troubled by some of the methods used to reach these goals.

Construction is cyclical, with the number of employees working for a contractor rising and falling depending on the contractor's success in being the low bidder on a specific construction project. This scenario makes an employer mandate unworkable. While the need for insurance is constant, the cost of employers either continuing to cover employees during off-times or having to frequently cancel and reinstate workers based on the fluctuations in the number of construction projects they have would be impossible financially and an administrative nightmare.

Construction has been struggling with tough economic times. We are coming off of a 5 year decline in construction. During this recession our industry has lost a million jobs. If the employer mandate (which adds eight percent to payroll costs) had been in place, one can only imagine how much earlier those jobs would have been lost to the economy.

Under the Health Security Act, employers will be required to pay 80 percent of their employees' insurance premiums. According to a Personnel Administrative Services' survey of one thousand merit shop contractors (ranging in volume from under \$500 thousand in revenues to more than \$50 million in revenues) the vast majority of companies are providing health insurance to their employees. (see table attached) In fact, more are doing so now than five years ago. As one might suspect, the figure for shared costs of the benefit has also risen. The survey results show that for companies with less than \$500 thousand in revenues, 73 percent were offering health benefits to their employees in 1988 - while this figure dropped slightly to 71% in 1993, in all other categories the number of firms offering coverage increased during the last five years. For businesses with revenues of \$500 thousand to \$1 million, 80 percent provided health benefits in 1988. That number increased to 86 percent in 1993, with shared costs actually decreasing from 35 percent in 1988 to 31 percent in 1993. Eighty six percent of companies with \$3-6 million in revenues provided health benefits to their employees in 1988 - 90 percent are doing so in 1993.

These statistics indicate that contractors are voluntarily taking care of their workers. They are customizing benefits to local conditions and the unique characteristics of the construction workforce. We believe any health care reform must reflect the realities of the work place and that this type of flexibility is crucial for our industry.

The President's plan promises to help small businesses comply with the employer mandate by offering sliding scale subsidies for businesses with fewer than 75 employees and offering premium caps to 3.5 percent of payroll. In reviewing the proposal, though, ABC is unconvinced that either of these accommodations will make it any easier for a construction employer to comply with the employer mandate. Without question, even though a business owner may want to provide coverage for his or her workers, in a business where companies succeed or fail based on a sealed bid, owners are forced to watch the bottom line. To do that and reduce operating expenses, the easiest place to start is to cut payroll, especially lower wage, marginal jobs and all of the required payments which accompany those positions.

A recent Employment Policies Institute study estimates that the impact on construction from enforcement of the proposed mandate will be to increase labor costs by 5.1 percent. Economist Jacob Klerman of the Rand Corporation, appearing before the Senate Labor and Human Resources Committee in October, testified that "recent research on mandated benefits suggests that most, if not all of the increased labor costs -- net of any government subsidies -- will be passed on to workers in the form of lower wages." Although experts differ on the number of jobs lost from the imposition of a mandate, the Employment Policies study puts the potential job loss for construction at 241 thousand jobs.

Another potential loss that comes from implementing an employer mandate is that employers no longer would have the flexibility or opportunity to design health plans suited to the needs of their employees working in a specific industry. Employers will also lose control over their health plan costs. The government will tell them what to pay. As such, employers will become indifferent as they will have no involvement in the costs. This would be quite a contrast to today, where each employer has the ability to shop the market.

As an example, I want to talk about a very successful program we have instituted at my company, TD Mechanical. TD Mechanical is an employee-owned company. We currently employ approximately 600 partners. Four years ago our health care costs were soaring, paralleling the increases prevalent in the health care industry. Our health care plan at the time was administered by an independent third-party company. We decided to take a more active role in the administration of health benefits and established a Health Care Quality Team. I headed up this effort.

The first major step was to terminate our third-party administrator and replace it with a company whose primary interest is educating and informing its customers. By working together with a client-oriented administrator, our Health Care Quality Team could analyze where our money was going. We then set out to bring our coverage in line and shopped for the best source for affordable and quality coverage. TDPartners (employees) participate in the overall cost of the plan by contributing 50 percent of the cost, the company picks up the other half. The annual total cost of health coverage for an employee is \$2400, almost \$1100 less than the lowest average for medical benefits in our area.

TD has been aggressive in educating our partners and empowering them to take responsibility for their own health care. This year we were able to provide a full cancer screening for only \$18 for those partners participating in the health plan. We made the service convenient by using a mobile unit that allowed screening to take place at our office and at key construction jobsites. We have instituted a "No Smoking" policy at our facility as well as an offer to subsidize the purchase of nicotine cessation patches for those smokers who wish to "kick the habit." We also educate our partners by publishing a quarterly health care magazine filled with health tips and distribute updates on the health care plan in the form of paycheck inserts. TD is committed to helping its workforce lead healthier, more productive lives.

We know we are not the norm. But we are an example of innovation for other employers to follow. We have created incentives for our employees and they know we are in this together. ABC believes an employer mandate destroys any motivation for businesses to take charge of their own health care costs. Once that occurs, the price of health benefits becomes relegated to a fixed business cost.

To assist construction employers in taking charge of their health care costs, ABC provides a variety of cost containment incentives, as well as a variety of health care plans. We began more than thirty years ago by first encouraging and then requiring second opinions. Today ABC provides a menu of benefits from the traditional fee for service programs with varying deductibles to Preferred Provider options or Point of Service programs, as well as Health Maintenance Organizations (HMO) in certain areas. This gives the small employer the ability to tailor a plan to

include specific coverage or financial requirements.

As one can imagine, it is common practice in construction to hire part-time workers. The President has proposed that these workers be covered under regional alliances, regardless of whether they work for a regional alliance or corporate alliance employer. All employers -- regardless of what type of alliance they are in -- contribute a pro-rated portion of the regional alliance's appropriate per worker premium, based on a 10-30 hour work week. Low income workers would be eligible for a subsidy. In yet another example of how the private sector has adapted to meet the special demands of its particular industry, ABC has made available unique benefit programs that provide coverage for hourly workers. ABC has developed a Dollar Bank program which is a specialized option under a "cafeteria plan". The plan was initially utilized on prevailing wage projects so that employers could pay for benefits on an hourly basis versus the traditional monthly cost. This payment of benefit on an hourly basis has expanded from the prevailing wage concept to numerous other commercial projects and provides an alternative whereby employers can contribute to the cost of coverage for employees who are considered less than full time and would normally not be eligible for health care coverage due to their part time status. Portability of coverage from one area of the country to another is also enhanced through this system plus the availability of a nation wide association type program such as ABC's. An employee can transfer his coverage and banked credits from one ABC employer to another when both participate in the association's plan.

One of the most controversial aspects of the President's proposal is the new bureaucracy designed to accompany reforming our health care system. The track record for containing growth in government is poor. Although many Americans concede that some type of health care reform is needed, the idea of building a new government organization to oversee our health care system is unlikely to ever sell.

ABC also disagrees with the concept that virtually all health care policies be purchased through singular, exclusive, state-established, non-voluntary, quasi-governmental entities known as "Health Alliances." This puts us on the road to a nationalized, single-payer system. The Health Security Plan prohibits association health care plans and other voluntary pooling arrangements. We think this is one example of why the President's plan is more "management" than "competition". ABC urges the Subcommittee to consider that association health plans and other voluntary pooling arrangements are competitive, affordable health alliances that work. The ABC Insurance plan has been around since the 1950's when several of our first members, all small businesses, were unable to get health insurance on their own. They decided to pool their resources and used their new found market leverage to negotiate benefits from competing insurers. Arrangements like these have provided competitive benefits through the years; those that were unable to compete fell victim to market forces. We think these proven arrangements deserve a place in any reform.

The President's plan dramatically changes the Employee Income Security Act (ERISA) and its safeguards. For instance, self-funded plans, or those financed by a business with its own funds and covering less than 5000 employees will cease to exist, as will association insurance plans. Many of these plans have set the current trends and provide workers and their families with needed protection.

Currently ERISA exempts self-funded plans from state laws, including those mandating health benefits and various state taxes. Thus, premiums for these plans are usually lower. National uniformity laws like ERISA benefit multi-state employers by creating administrative efficiency, cost-effectiveness and all the advantages that come with belonging to a large risk pool. ABC believes these changes will negatively impact contractors large and small. Therefore, we support continuation of ERISA and urge the Subcommittee to think carefully before allowing a hodgepodge of potentially 50 different sets of rules and regulations governing health, welfare, and training benefits.

ABC is also concerned about provisions of the proposal that revise current income and employment tax provisions relating to the classification of individuals as employees or independent contractors. In general, these provisions grant the IRS more power than Congress, make a regulation more powerful than legislation, and give the IRS extraordinary authority to not only define an "employee" or "independent contractor" for health care purposes but also for employment purposes and income taxes. Specifically, the package repeals current law that prohibits Treasury from issuing regulations on the classification of "employees". Also, it requires Treasury to issue regulations to determine whether an individual is an employee for employment and income tax purposes. The proposal states that Treasury regulations on the classification of "employees" will override current statutes and rules on the classification of employees. Also, under section 530, current safe harbor provisions would be repealed and replaced with less favorable ones. The new safe harbor rules make it more difficult for employers to rely on "prior IRS audit" and "long-standing industry practice" safe harbors to classify individuals as independent contractors.

ABC has submitted testimony to the House Ways and Means Committee numerous times on the independent contractor issue and the need for reform of the common law test that determines worker classification. We believe the sweeping changes embodied in the health care reform plan give the IRS far too much power; that this is an inappropriate place to address this complicated issue; and their inclusion sets a dangerous precedent that needs to be curbed.

The White House says over the next two years, one of every four Americans will lose health coverage for some time. The President's plan guarantees you will never lose your insurance, no matter what. ABC believes this feature is of the utmost importance due to the mobility prevalent in the construction industry workforce. We are glad to see the portability issue addressed, but we are wary that, as proposed, it will be complicated, bureaucratic, expensive and not deliver the desired protections.

Finally, ABC takes strong issue with statements made by the Building and Construction Trades Department of the AFL-CIO before this subcommittee last Thursday. The testimony of Robert Georgine stated on page 6 "the typical non-union contractor does not provide health insurance for its employees... or provides inadequate coverage."

The testimony also said that:

"while we have struggled to ... maintain responsible health coverage for our members, our non-union competition have gained an unfair advantage. Non-union contractors have found a way to shift the cost of medical treatment for their employees and families onto the back of our health and welfare plans and members. The unfair competitive advantage is further multiplied when the uninsured non-union worker or his family needs medical treatment. Lacking insurance coverage, they have no regular doctor, but rather go to hospital emergency rooms for treatment of minor and major ailments; the most expensive place to get treatment. And, when the worker is unable to pay for the treatment, the cost is passed onto our multi-employer health and welfare plans in the form of higher hospital bills, higher insurance premiums."

We want to set the record straight. Earlier in this testimony we demonstrated that a substantial majority of merit shop contractors do provide health care benefits. Unions are nervous that the Cadillac plans they have built up over the years as a means of hanging on to their member are in jeopardy. A "standard benefits package" is the catchy phrase all the reform proposals are touting now and the unions know they will have to change with the times. The standard package offers considerably less than the generous plans unions have held out for in bargaining sessions. Cadillac plans have driven the cost of construction up. It is not enough that organized labor received sizable

concessions in the proposal, including a promise that benefits in contracts negotiated this year could continue for 10 years, protections for Taft-Hartley multi-employer plans and a 10 year break before their liberal packages, which are far over and above the standard, would be taxed. Although unions have endorsed the Health Security Plan, they must realize that the scale back in benefits may well be one more disincentive to join organized labor. The cost-shift argument is simply untrue. Merit shop contractors, by their sheer number, (i.e. 80 percent of the workforce) compared to the building trades' (20 percent), bear a far greater share of the public costs than do the unions. It is time that all construction be on the basis of quality, productivity, safety and not crying to protect outdated and inefficient health plans.

I appreciate the opportunity to appear before you and I will be happy to answer any questions you may have.

Comparison of Eight Benefit Increases/Decreases From 1988 to 1993 For Merit Shop Contractors

(Figures shown are the percentage of companies providing the benefit listed)

Company Size	3-6 Million		6-10 Million		10-20 Million		20-50 Million		Over 50 Million	
Benefit	1988	1993	1988	1993	1988	1993	1988	1993	1988	1993
Health Insurance	86	90	88	95	88	94	88	93	88	79
Shared Cost	36	45	35	49	37	40	38	49	38	60

Chart taken from the Contractor Compensation Quarterly, Vol. 1, Issue 4.
Data compiled from the PAS Merit Shop Wage & Benefit History.



November 15, 1993

Ms. Janice Mays
Chief Counsel and Staff Director
Committee on Ways and Means
1102 Longworth Building
Washington, DC 20515

RE: Addition to testimony for Hearing Record, ABC's testimony before Health Subcommittee on November 4, 1993, "Impact of the Clinton Health Plan on the Economy and Jobs"

Dear Ms. Mays:

Associated Builders and Contractors (ABC) testified before the Health Subcommittee on Thursday, November 4th at a hearing entitled "Impact of the Clinton Health Plan on the Economy and Jobs." Included in our testimony was a chart showing a comparison of benefit increases/decreases from 1988-1993 for merit shop contractors. Specifically, figures were given for health insurance benefits for firms with \$3 million in revenue on up to over \$50 million in revenue. Our *testimony*, however, presented the statistics for companies whose figures were not included in the chart. We opted to discuss those companies with smaller revenues since they are a better reflection of the typical ABC member.

All of the statistics are valid and derived from the *Contractor Compensation Quarterly*, Volume 1, Issue 4. Data compiled from the *PAS Merit Shop Wage and Benefit History*.

Thank you for this opportunity to clear up any confusion. I apologize for any inconvenience.

Very truly yours,

Betsy Laird
Legislative Representative

Mr. COYNE. Well, thank you, Mr. Reeve, and thank all the panelist for your testimony and being with us today.

The previous panel, as most of you heard, who were mostly large employers, suggested reducing the minimum size of an alliance before a firm could set up a corporate alliance.

Do any of you have views on that proposal? And in your judgment—is 5,000 too large?

Ms. CARROLL. It is interesting that, depending upon at what point you define the size of small business, companies want to opt out of the regional alliance. And I think that maximum group size will continue to be whittled down. People are now thinking that an acceptable number is 100, yet if you look at this country, the majority of small firms are of 1 to 100. In any given State you are probably talking about 70 to 80 percent of all companies in that State having 100 employees or less.

I don't think the alliances are going to prevent the cost-shifting effects they are supposed to protect small companies from because as long as there are experience rated and self-insured companies, they will continue to cost shift on to the smaller business community, regardless of how you structure the pool.

I think the pool savings itself, especially in a mandatory and exclusive situation, is a fallacy.

Mr. COYNE. Thank you. Would anyone else want to comment?

Mr. ALFONSO. I would say from NSBU's standpoint, beyond just the size of the alliance, our position would be that there should be some competition and not just one alliance in a particular area. We don't think that that would foster good competition and lower costs for health care, that some type of choice between the alliances, at least one choice within that region would allow businesses to select a particular best, lowest cost type of alternative, and right now the plan calls for a single alliance in one particular area, but we would highly recommend that change.

Mr. DUNKELBERG. I guess I would suggest that it is very difficult to sit here and pick a number. My view would be companies will form alliances when they can do it better and cheaper, so why do we want any restriction? If someone wants to form—if a group wants to form an alliance because they can do a better job and a cheaper job, they should be allowed to do that regardless of the size.

Mr. REEVE. I agree. I think our own company's experience has shown us very clearly that when we get involved with the management of our plan that we can make a significant difference in the total cost expended and still provide very good coverage for our employees and their families.

Without having that involvement, however, the costs go uncontrolled through the roof and so we want to have choice involved in any reform, and we want to have the private enterprise be strongly encouraged to take control of their own situations.

Mr. COYNE. If you can respond to this question, how could multiple voluntary alliances compete without adverse selection causing major problems? Do you have any thoughts on that?

Ms. CARROLL. You have to start off with looking at the principles of small group market reform, and extending those to both multiple

employer trusts and MEWAs, first of all. Then extending these to all insurers.

Most States have now enacted some type of small group reform legislation. In those States where it is based on more of a guarantee issue community-rated model, what you will find is that there are always pockets and groups that will fight with their local legislators and State legislators to make sure that they are exempted. Also, multiple employer trusts and MEWAs have, because of ERISA, been exempted and are allowed to continue cherry picking within any given market when other plans are guarantee-issued and community-rated. That is where the selection problems come in.

I think you start with the principles of small group reform across the board, looking at a guarantee issue, community-rated plan; it doesn't have to be pure community rating. That will be dependent on each State, I think, and then look at the nongroup market because a lot of your problems with selection are in the nongroup market.

People who don't have continuity of coverage because their spouse has gone on to Medicare and now the wife is left without insurance because there is no continuity; those are a lot of loopholes in the existing system that I think can be fixed in order to cut down on the selection problems.

Add to that an annual open enrollment process so you prohibit people from just hopping between alliances at any given point in time, primarily because they want a different provider. There shouldn't be rate hopping if everyone is on the same community-rated basis, therefore that shouldn't be a factor anymore.

Mr. COYNE. OK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. Thank all of you for staying so long.

Mr. ALFONSO, you said that your association would prefer an individual-based approach rather than an employer-based approach. Would you expound upon that a little bit, please. What do you mean by that?

Mr. ALFONSO. Certainly we would want to possibly submit that in writing in terms of a detailed plan, but we certainly feel that as opposed to having the government provide a plan that is employer-based, and you are subsidizing businesses that can't meet the needs of health care, that if you look at it and reverse that and require individually-based requirements on health care, that businesses who are currently providing health care will continue to do so. They will compete for that same labor force, and so individuals will have a choice of employment, but those that fall below the poverty line, those that are unemployed are individuals that need social help that the government could subsidize individuals, so individuals would have the responsibility of making sure that they have health care coverage as opposed to putting it—mandate it on businesses.

It is probably a more manageable type of plan overall, and NSBU would want to submit a more detailed description of that at a later time.

Mr. MCCRERY. OK. That would be good. But basically you would prefer an individual mandate to an employer mandate?

Mr. ALFONSO. That is correct.

Mr. MCCRERY. OK. Mr. Reeve, you talked a lot about members of your association being able to lower their costs for health insurance over the last couple of years, getting it down now to about \$2,400 a year per person.

Mr. REEVE. That is for our own company, not for our association, as an example.

Mr. MCCRERY. For your company. Besides encouraging wellness and all that, how have you been able to do that? Have you provided a lower level of benefits for your employees or higher deductibles? Just how did you accomplish that?

Mr. REEVE. We believe that the health care coverage that we offer all of our employees is commensurate with our industry, and our cost sharing for medical treatments is an 80/20 after the \$250 deductible has been met, and so we think our plan is very competitive. We think that we have a somewhat unique situation in that we are an employee-owned company, and so we have a lot of employee involvement in our company from that standpoint.

When the health care committee was formed it was generally known throughout our employee population that now they had a stronger voice in their health care than they had before because these are employee representatives. The other big thing I think is that we—the committee communicated over and over to our employees that this is our plan, this is not a third party insurance company. This is your money and my money, and we are pooling this money together to provide adequate health coverage for us and our families, and continuing to repeat the message of getting them to buy into that this is their plan, this is their money that they are spending, makes us better utilizers of the health care services.

What we fear as a company about the administration's plan is that this very foundation, this ownership in controlling health care costs, will be totally lost because you are just delegating the cost control to an umbrella bureaucracy, in a regional association, that we know will not be effective at controlling health care costs.

Mr. MCCRERY. How many employees do you have?

Mr. REEVE. Six hundred.

Mr. MCCRERY. Is the \$2,400 figure per person or per family?

Mr. REEVE. Per person average. It varies from approximately \$72 per individual employee to \$413 per month for an employee plus family. One of the things that we did was change our third party administration. Our previous third party administrator simply processed the claims and tacked their administration fee on it and gave us a bill. They had no record-keeping controls, and we didn't really know where our costs were being spent.

We changed administrators and have a much more proactive administration group that provides us with a lot of details about where our health care dollar is being spent. We know by category, by employee, by spouse, by children, where the dollars go, and so we are able to communicate more effectively with those groups, in our groups.

Since we are a construction company most of our employees are men, so the spouses are mainly—

Mr. MCCRERY. I get the picture. We have got to go vote. I want to get one more question in before I pass the baton here. Mr.

Dunkelberg, you said that health insurance today, in many cases, is not really insurance at all, it is prepaid.

Mr. DUNKELBERG. Medical care.

Mr. MCCRERY. Prepaid medical care. I agree with you. Then you went on to say that we need to have a choice or we need to have choices. What did you mean by that?

Mr. DUNKELBERG. I think the fundamental thing we have to keep in mind is if you want to control costs, you have to give someone the incentive to control costs. Most of the insurance systems—and the one that I have, which is like a first dollar coverage, Blue Cross-Blue Shield deal, nothing I do can affect my premium, nothing I can do affects my cost, I am not in control.

One wonders why, since, again, individuals have the responsibility for getting food, shelter, housing, and so on, why we don't pay routine maintenance like we require food and so on, then if you get into trouble it cuts in. How would the insurance cut in? Well, it could be fixed dollar amount or it could be a percentage of your income so if you are unemployed it would come to zero. It pays everything until you get a job, but that is insurance, and that protects me from accidents and so on, but it gives me the responsibility for controlling costs on a day-to-day basis.

That is where the big health care bill comes, it is not the extravagant stuff. It is all of us doing the day-to-day stuff. That is where we don't have control today, and plans like this one do put the control back in the hands of individuals.

Copay doesn't work because I still have to pay it, and I can't affect it. I have to have control of it, and then we can get the job done, but then choices will matter because I can then pick.

Mr. MCCRERY. Thank you.

Mrs. JOHNSON. I just want to thank you for your testimony. You brought out exactly the points that all of us worry about. Would you, though, make it your business to get back to us with examples of how companies have controlled costs, and Mr. Reeve, yours are very impressive, but there are also groups of small companies that have voluntarily banded together and kept their premium increases to zero or negative, and we need those because there are the small businesses that have still been the victims of 20 and 30 and 40 percent premium increases, and we need to counter that with the concrete examples that we know are making a change in the short term and immediately and will affect the future.

Thank you. We all have to vote, so thank you for your testimony.

Mr. DUNKELBERG. Thank you.

Mr. COYNE. Thank you for your testimony. The meeting is adjourned.

[Whereupon, at 4:35 p.m., the hearing was adjourned.]

[A submission for the record follows:]

**STATEMENT OF WILLIAM S. CUSTER, PH.D.
DIRECTOR OF RESEARCH
EMPLOYEE BENEFIT RESEARCH INSTITUTE**

Mr. Chairman, I am pleased to submit this statement for the record on the estimates of the impact of the Clinton Administration's health care reform proposal on jobs. The Employee Benefit Research Institute (EBRI), a nonprofit, nonpartisan public policy research organization, is dedicated to providing objective analysis of health care and other work force issues. To that end, this testimony reflects the research EBRI has compiled on the possible effects of an employer mandate under the Administration's health care reform proposal. Using a variety of assumptions, EBRI has produced a range of estimates on the employment effects of the Administration's employer mandate of between 661,000 net jobs created to 158,000 net jobs lost. However, the Administration's proposal for determining the employer contribution is likely to reduce the cash income of lower wage workers and increase the cash income of higher wage workers.

ESTIMATES OF JOB LOSS DUE TO AN EMPLOYER MANDATE

Analysts must make three basic assumptions in order to arrive at an estimate of the impact of an employer mandate on jobs. First, they must determine the cost of the benefit being mandated. Second, they must use an estimate of the sensitivity of the demand for labor to a change in the cost of labor. Finally, and most importantly, they need to make an assumption about the operation of the labor market and the speed with which it adjusts.

In the long run, mandating that a benefit be offered does not affect the labor market. In general, it does not affect the intrinsic value of a worker to an employer or change the number of workers available. It does affect the composition of total compensation, which may have important policy and economic implications, but it will not affect the number of jobs.

In the short and medium run, however, markets may not adjust completely. In these cases, the cost of the mandate will be divided among: workers in the form of lower wages and/or fewer jobs; employers in the form of lower profits; and consumers in the form of higher prices. Similarly, the benefits of a cap on employer contributions for health benefits will be divided among workers, employers, and consumers. The actual share of the burden or benefit is likely to vary by geographic region, occupation, industry, and size of employer.

As a nonpartisan, nonprofit research institute, EBRI's role in the health care debate is to provide objective information on the tradeoffs inherent in all the health care reform proposals. To that end, we have developed our own micro-simulation model to: understand how researchers arrive at widely different estimates, examine the sensitivity of these estimates to different assumptions, and understand the weaknesses in the methodologies employed. By examining the assumptions and methodologies used in the various estimates of the impact of an employer mandate, we can place reasonable bounds around the likely impact of an employer mandate on employment.

The Employment Policies Institute (EPI) released a report that contained estimates of 3.1 million jobs lost as a result of an employer mandate. The study was done before the Clinton Administration released its health plan, so it did not incorporate the actual mandate contained in the Administration's proposal. EPI assumed that benefits would cost \$2,400 for an individual and \$5,900 for a family. They further assumed that employers would pay 90 percent of the premiums. Finally, they assumed that wages would not change as a result of an employer mandate, so that employers would bear the full costs. They used the March Supplement to the 1991 Current Population Survey to derive their estimate. Using similar, but not identical, methodology and EPI assumptions on the premiums, we arrived at an estimate of 2.9 million jobs lost due to a mandate, using the March Supplement to the 1993 Current Population Survey.

In contrast to the assumptions used in the EPI and most other studies of the effects of an employer mandate, the Clinton Administration's proposal creates four premium categories: single adults, single adult families, couples with no children, and couples with children. The employer's contribution for each worker in each category is 80 percent of the premium divided by an adjustment factor. The adjustment factor is the number of workers in each category divided by the number of families of that type in each category in the alliance. Thus, the actual costs to the employer for family coverage are lower than the costs to employers who provide such coverage now. In fact, this methodology results in a subsidy for one-worker couples paid by two-worker couples. That is, the sum of the contributions (employer plus family) of two-worker couples will exceed the premiums for their premium category, while the sum of the contributions of one-worker families will be less than the premiums for their premium category. It is important to note that, as shown in table 1, the adjustment factor, and therefore the employer contribution, varies dramatically from state to state.

The Clinton Administration's proposal also caps the costs employers must pay as a percentage of payroll. At most, employers are required to pay 7.9 percent of payroll, although the amount may be as low as 3.5 percent for firms with fewer than 25 workers and average wages of less than \$12,000.

Using the assumption that wages or other benefits do not adjust, so that any cost increases or savings due to the mandate are borne by the employer, we find that the Clinton Administration's proposal would create between 631,000 and 661,000 net new jobs (see tables 2, 3, and 4), depending on the premiums. Approximately 600,000 jobs would be lost from those employers who face new costs, and approximately 1.3 million new jobs would be created by those employers who experience lower costs as a result of the mandate.

The assumption that wages or other benefits would not change after a mandate is enacted, or announced, is highly unrealistic. It represents an upper bound on change in the employment that would result from an employer mandate. At the other extreme is the assumption that wages adjust, upward or downward, to completely absorb the costs of an employer mandate. In this case, the employers' costs are unchanged and their demand for labor would be unchanged, except for those workers at or near the minimum wage. Those workers' wages could fall to the minimum wage but no further, so employers of minimum wage workers would face higher costs as a result of the mandate. Using the assumption that wages adjust completely except for those workers near the minimum wage, we estimate that an employer mandate would cause about 158,000 jobs to be lost. This estimate would be larger if higher premiums were used in the simulation.

Using the national average premiums estimated by the Clinton Administration, a reasonable range for the impact of the employer mandate on jobs is between 661,000 net jobs created and 158,000 jobs lost. Higher premiums would reduce the number of jobs created at one extreme and increase the number of jobs lost at the other extreme, but it is unlikely that the range would exceed one-half of 1 percent of the work force in either direction.

It is important to note, however, that an employer mandate results in a redistribution of income. Higher income workers are more likely to have coverage currently than lower income workers. Many of these workers will find that their wages or other benefits increase as a result of the mandate. Conversely, those workers who do not now receive health insurance through their employer tend to be lower-income workers. These lower income workers will find that their real wages will fall or their jobs will become less secure, or both, as a result of the mandate. Many of these workers will find they now have a health insurance benefit that they did not have before, but 30 million of those who do not now get coverage from their employer have coverage from a spouse's plan or presently purchase coverage as individuals. While the benefit package under the Administration's proposal may be more generous than the plans these individuals now have, it is unclear if they will feel they are better off as a result of this reform.

The views expressed in this statement are solely those of the author and should not be attributed to the Employee Benefit Research Institute, its officers, trustees, sponsors, or other staff. The Employee Benefit Research Institute is a nonprofit, nonpartisan, public policy research organization.

The following tables compare the job loss or gain estimates resulting from an employer mandate using a variety of assumptions. The tables demonstrate the sensitivity of these estimates to assumptions used. Each column represents the results of simulations using a particular set of assumptions:

Column (1): These estimates assume a family premium of \$5,900 and an individual premium of \$2,400. All families composed of more than one person pay the family premium. It is assumed that employers contribute 90 percent of these premiums. It is assumed that wages and other compensation do not change with the implementation of the employer mandate.

Column (2): These estimates assume a family premium of \$5,900 and an individual premium of \$2,400. All families composed of more than one person pay the family premium. Employers contribute an amount equal to 80 percent of the premium divided by an adjustment factor. This adjustment factor is equal to the number of workers in families with two adults divided by the number of families with two adults. Employer contributions are capped at 3.5 percent of payroll for individuals[†] employed by employers with fewer than 25 employees and having wages of less than \$24,000, increasing to 7.9 percent for employers with more than 75 employees. It is assumed that wages and other compensation do not change with the implementation of the employer mandate.

Column (3): These estimates assume premiums to be \$1,800 per single adult, \$3,630 for a single adult with children, \$3,600 for a couple with no children, and \$4,200 for two adults with children. All families composed of more than one person pay the family premium. Employers contribute an amount equal to 80 percent of the premium divided an adjustment factor. This adjustment factor is equal to the number of workers in families with two adults divided by the number of families with two adults. Employer contributions are capped at 3.5 percent of payroll for individuals[†] employed by employers with fewer than 25 employees and having wages of less than \$24,000, increasing to 7.9 percent for employers with more than 75 employees. It is assumed that wages and other compensation do not change with the implementation of the employer mandate.

Column (4): All assumptions are identical to Column (3) except that wages are assumed to adjust to completely eliminate the change in total compensation, except for workers close to the minimum wage. For these workers, wages are assumed to fall to the minimum wage, and employers will bear any additional costs due to the mandate.

[†] Note the difference between this estimation assumption and the Clinton proposal, which uses average payroll of the employer, rather than the individual's wages and has a sliding scale for the premium cap that is 3.5 percent for employers with average wages of less than \$12,000 up to 7.9 percent for small employers with salaries of over \$24,000.

Table 1
 Number of Workers per Unit Adjustment Factor:
 Determination of Employer per Worker Contribution, by State, 1991
 EBRI Tabulations of the March 1992 Current Population Survey (CPS)

	Couples with no children	Couples with children
National Total	1.43	1.53
State		
Alabama	1.31	1.53
Alaska	1.45	1.40
Arizona	1.34	1.45
Arkansas	1.33	1.62
California	1.37	1.44
Colorado	1.41	1.48
Connecticut	1.65	1.59
Delaware	1.48	1.59
District of Columbia	1.49	1.53
Florida	1.32	1.55
Georgia	1.39	1.80
Hawaii	1.68	1.62
Idaho	1.29	1.52
Illinois	1.55	1.54
Indiana	1.42	1.58
Iowa	1.49	1.68
Kansas	1.50	1.58
Kentucky	1.28	1.34
Louisiana	1.29	1.50
Maine	1.41	1.54
Maryland	1.63	1.61
Massachusetts	1.56	1.49
Michigan	1.43	1.49
Minnesota	1.54	1.68
Mississippi	1.23	1.56
Missouri	1.48	1.67
Montana	1.32	1.55
Nebraska	1.45	1.73
Nevada	1.48	1.52
New Hampshire	1.61	1.54
New Jersey	1.67	1.49
New Mexico	1.25	1.48
New York	1.46	1.45
North Carolina	1.43	1.60
North Dakota	1.33	1.68
Ohio	1.40	1.52
Oklahoma	1.41	1.43
Oregon	1.34	1.53
Pennsylvania	1.48	1.47
Rhode Island	1.57	1.47
South Carolina	1.46	1.63
South Dakota	1.36	1.73
Tennessee	1.40	1.59
Texas	1.36	1.54
Utah	1.49	1.56
Vermont	1.49	1.65
Virginia	1.58	1.65
Washington	1.28	1.51
West Virginia	1.16	1.35
Wisconsin	1.53	1.74
Wyoming	1.25	1.57

Table 2
Estimates of Job Losses (-) or Gains due to an Employer Mandate Using Various Assumptions
on Costs to Employers, Caps on Employer Contributions, and Changes in Wages,
By Employer Size

Number of Employees	(1) High Premiums Current Methodology	(2) High Premiums Clinton Methodology	(3) Clinton Premiums Clinton Methodology	(4) Clinton Premiums Wages Adjust
Under 10	-677,938	13,253	16,975	-36,618
10 to 24	-431,349	53,068	55,793	-24,485
25-99	-507,764	153,547	157,634	-30,125
100-499	-397,714	89,662	94,954	-22,088
500-999	-145,630	52,568	54,510	-6,841
1,000+	-821,772	269,092	281,646	-48,109
Total	-2,982,166	631,190	661,512	-168,265

Source: EBRI simulations using the March 1993 Supplement to the Current Population Survey (CPS). Employer Contributions are derived from the National Medical Expenditure Survey, adjusted for inflation, and imputed to the CPS.

Table 3
Estimates of Job Losses (-) or Gains due to an Employer Mandate Using Various Assumptions
on Costs to Employers, Caps on Employer Contributions, and Changes in Wages,
By Average Hours Worked Per Week

Average Hours Per Week	(1) High Premiums Current Methodology	(2) High Premiums Clinton Methodology	(3) Clinton Premiums Clinton Methodology	(4) Clinton Premiums Wages Adjust
10-20 hrs	-68,160	18,052	21,179	-29,495
20-30 hrs	-913,249	61,478	64,236	-51,974
30-35 hrs	-404,856	35,094	37,098	-26,474
Full Time	-1,595,900	516,566	538,999	-60,322
Total	-2,982,166	631,190	661,512	-168,265

Source: EBRI simulations using the March, 1993 Supplement to the Current Population Survey (CPS). Employer contributions are derived from the National Medical Expenditure Survey, adjusted for inflation, and imputed to the CPS.

Table 4
Estimates of Job Losses (-) or Gains due to an Employer Mandate Using Various Assumptions
on Costs to Employers, Caps on Employer Contributions, and Changes in Wages,
By Family Income

Total Family Income	(1) High Premiums Current Methodology	(2) High Premiums Clinton Methodology	(3) Clinton Premiums Clinton Methodology	(4) Clinton Premiums Wages Adjust
Under \$5,000	-592	-43	-43	-22
\$5,000-10,000	-195,773	4,568	4,654	-11,649
\$10,000-15,000	-383,758	49,820	50,149	-21,776
\$15,000-20,000	-323,126	94,219	94,835	-16,352
\$20,000-30,000	-543,634	169,641	172,564	-34,366
\$30,000-50,000	-790,316	262,313	268,435	-42,448
\$50,000-100,000	-656,840	73,821	89,387	-36,460
\$100,000 or more	-88,127	-23,148	-18,468	-5,192
Total	-2,982,166	631,190	661,512	-168,265

Source: EBRI simulations using the March, 1993 Supplement to the Current Population Survey (CPS). Employer contributions are derived from the National Medical Expenditure Survey, adjusted for inflation, and imputed to the CPS.

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